Achieving Equity, Coverage, and Impact through a Care Group Network

Sofala Province, Mozambique
October 1, 2005 – September 30, 2010
Cooperative Agreement No. GHS-A-00-05-0014-00

Final Detailed Implementation Plan

Submitted by:
Food for the Hungry, Inc.
236 Massachusetts Ave., NE, Suite 305
Washington, DC 20002
Tel: (202) 547-0560 FAX: (202) 547-0523
Contact: Lauren Erickson-Mamane (Lauren.Erickson@fh.org)
Child Survival and Nutrition Programs Coordinator, Food for the Hungry

Authors:

Lauren Erickson-Mamane, MPH, CS and Nutrition Programs Coordinator
Tom Davis, MPH, Director of Health Programs
Emma Hernandez Avilan, BSN, Child Survival Program Manager

June 30, 2006

TABLE OF CONTENTS

ACRONYMS AND ABBREVIATIONS USED IN THIS DIP

ABY	Abstinence, Being Faithful program for Youth (PEPFAR funded)
AFASS	Acceptable, Feasible, Affordable, Sustainable, Safe
AISPO	Italian Association for Solidarity Among People
ANC	Antenatal Care
ARI	Acute Respiratory Infection
BCC	Behavior change communication
BF	Breastfeeding
BMI	Body mass index
CED	Chronic energy deficiency (BMI<18.5)
CG	Care Group
CI	Confidence Interval
CQI	Continuous quality improvement
CS	Child Survival
CSHGP	Child Survival and Health Grants Program
CSNPC	Child Survival and Nutrition Program Coordinator (the HQ backstop)
CSP	Child Survival Program / Project
CSP Manager	Child Survival Program Manager (Mozambique)
CSTS	Child Survival Technical Support program
CORE	Child Survival Collaborations and Resources Group (an umbrella group of PVOs involved in child survival projects)
CUAMM	Doctors with Africa (Italian NGO)
DAP	Development Activity Proposal
DHP	Director of Health Programs
DHS	Demographic and Health Survey
DIP	Detailed Implementation Plan
DPT	Diphtheria Pertusis Tetanus vaccine
EPI	Expanded Program of Immunization
FAM	Food Aid Management
FFP	Food for Peace
FH	Food for the Hungry International
FH/M	Food for the Hungry Mozambique
FOCAS	Foundation for Compassionate American Samaritans (a PVO)
GM/P	Growth Monitoring/Promotion
HAI	Health Alliance International
HBC	Home Based Care (for people with HIV/AIDS and other chronic debilitating illnesses)
HFA	Health Facility Assessment
HH	Household
HH/C IMCI	Household and Community Integrated Management of Childhood Illness
HIS	Health Information System
HIV/AIDS	Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome
HNP Manager	Health and Nutrition Program Manager (Mozambique)
HPSO	Health Program Support Official (formerly “District Coordinator”)
HQ	Headquarters
IMCI	Integrated Management of Childhood Illness
IMR	Infant mortality rate
IR	Intermediate Results

JHU	Johns Hopkins University
KPC	Knowledge, Practice, and Coverage
LBW	Low Birth Weight
LM	Leader Mother
LQAS	Lot Quality Assurance Sampling
M&E	Monitoring and Evaluation
MEWG	CORE's Monitoring & Evaluation Working Group
MCH	Maternal and Child Health
MOA	Ministry of Agriculture
MOH	Ministry of Health
MOU	Memorandum of Understanding
NCR	Nutritional Rehabilitation Center
NGO	Non-governmental organization
NO	National Organization
NR	Nutritional Rehabilitation
NRC	Nutritional Rehab Center
ORS	Oral Rehydration Serum
ORT	Oral Rehydration Therapy
OVC	Orphans and Vulnerable Children
PD	Positive Deviant
PLWHA	People Living with HIV/AIDS
PVO	Private and Voluntary Organization
PWCSA	Provincial Women's Committee for Social Action and Coordination (Direcção Provincial da Mulher e Coordenação da Acção Social)
QI	Quality Improvement
QIVC	Quality Improvement and Verification Checklist
RHFs	Recommended home fluids (for use during diarrhea)
RBM	Roll Back Malaria
SBCWG	CORE's Social and Behavior Change Working Group
SO	Strategic Objective
STI	Sexually transmitted infection
TBA	Traditional Birth Attendant
TDH	Terra des Hommes
TIPs	Trials of Improved Practices
TOST	Training of Survey Trainers
TOT	Trainer of Trainers
U5MR	Under five mortality rate
UNDP	United Nations Development Program
UNICEF	United Nations International Children's Emergency Fund
USAID	United States Agency for International Development
VAD	Vitamin A deficiency
VCT	Voluntary Counseling and Testing
WAZ	Weight for Age Z-score
WDC	Washington, DC
WFP	World Food Program
WHO	World Health Organization
WR	World Relief
WRA	Women of reproductive age
WV	World Vision

A. Executive Summary

Mozambique ranks 168th out of 177 countries in terms of poverty (2005 UNDP Human Development Report) and currently 70% of the population of Sofala province lives on less than $1 per day. The under-five mortality rate (U5MR) for Sofala is 205 compared with 178 nationally and the infant mortality rate (IMR) is 149 (cf: 124 nationally). In addition, 42.3% of children 0-59m of age in Sofala province are stunted (HAZ<-2); 7.6% are wasted (WHZ<-2); and 26.2% are underweight (WAZ<-2). Forty-four percent of all deaths in Mozambique are malnutrition related.

Maternal nutritional practices in Sofala are poor. The percentage of children exclusively breastfed in project districts is only 17%. Feeding frequency and nutrient-density of foods given to children are both problematic. Only one-third of children in project districts (9-23m of age) receive three or more feedings per day apart from breastfeeding. Behavior related to diarrhea is also quite poor: while 90% of mothers in project districts have heard about ORS, only 44 % of mothers can correctly prepare ORS from packets.

To improve the health and nutritional status of children in Sofala, Food for the Hungry (FH) will implement a five-year (October 1, 2005- September 31, 2010) $3.3 million[1], Expanded Impact Child Survival Project utilizing the Care Group (CG) model.

This project will expand FH's successful Care Group model into ten districts in Sofala province. The CG methodology helps mothers to learn how to help their children survive and thrive, and to adopt new behaviors. In FH's methodology, an initial census is done to divide households with children under two years of age or pregnant women into groups of twelve. Each twelve-household group elects a LM under the guidance of the Promoter. A group of 14 LMs forms a Care Group. Each Promoter serves five Care Groups, and meets with the LMs in each Care Group every two weeks for two hours. During Care Group meetings, Promoters teach LMs weekly health messages using small flipcharts and other educational materials and methods. LMs discuss the health lesson, report on illnesses of children in the households they serve, discuss problem cases (e.g., in terms of behavior change), and report on vital events. LMs practice health promotion in pairs, and are supervised and coached by the Promoter. During the two weeks between Care Group meetings, each of the 4,830 LMs does health promotion through home visits to each of the twelve women/mothers that she serves (households with pregnant women or children under two). Children 24-59m of age are seen every six months and receive vitamin A, deworming drugs, and are screened for malnutrition.

Complimenting the work that has already been carried out by the MOH and other partners in clinical IMCI, all 69 Promoters and one Leader Mother per Care Group (345) will receive training in community and household IMCI, and learn to assess, classify, refer, and provide advice on home management to mothers in the communities where they work. FH and its partners in Sofala will jointly conduct training and supervision of Promoters to ensure that the partners can continue maintaining the structure once the project has ended.

[1] $2,499,910 USAID funds and $847,653 Match funds

FH has demonstrated this model to have a positive impact on malnutrition, mortality and results-level indicators of preschool children in Mozambique, as well as changes in maternal morbidity. During the period 1998 to 2001, FH/M decreased malnutrition by 40% (from 50.4% to 30.3%, $p<0.05$) with concomitant, dramatic changes in mothers' nutritional and other health practices using this model.[2] Preliminary results of a mortality study conducted in conjunction with World Relief and with the support of John Hopkins in 2004 found that the U5MR dropped by 62% (from 107/1000 to 41/1000), between 1999 and 2003 in areas where FH has used the Care Group approach in Sofala province. The IMR decreased from 66 to 38 (42%) in the same areas.[3]

The goals of this expanded impact program are to (1) significantly reduce morbidity and mortality – especially among children 0-23m of age and pregnant women – in Sofala province; (2) increase access to community and household IMCI-trained health providers in the program areas; and (3) to transfer the knowledge, skills, tools, and passion needed for effective and sustainable community health development through the Care Group model to project partners – including Leader Mothers – in order to continue child survival activities once this project has ended. FH estimates the **beneficiary population to be 198,594 people.** This included 21,521 pregnant women, 42,927 mothers of young children, and 134,146 children: 26,829 infants <12mths, 26,829 children 12-23 mths, and 80,488 children 24-59 mths.

FH will achieve these goals in partnership with the Sofala provincial MOH, the Provincial Women's Committee for Social Action and Coordination (PWCSA), Health Alliance International (HAI), and Doctors with Africa (CUAMM), with whom we have collaborated closely in the development of this plan. The Care Group model will be the chief means of implementing interventions for nutrition and diarrhea, integrated through the household and community IMCI strategy throughout the ten districts of Sofala province. The **nutrition** intervention will receive 70% of the project effort, and **control of diarrheal disease** will receive the remaining 30% of effort. To accomplish this, 69 Promoters and 4,830 Leader Mothers working through 345 Care Groups will be trained and operating in ten districts of Sofala Province.

This program has been thoroughly discussed with both Dr. Abuchahama Saifodine, the Acting Team Leader of the Office of HPN and Titus Angi, Health, Population and Nutrition Specialist, both with the USAID mission in Mozambique. The main writer of this DIP document was: Lauren Erickson-Mamane, Child Survival and Nutrition Program Coordinator, Food for the Hungry, 236 Massachusetts Ave., NE Suite 305, Washington DC 20002, lauren.erickson@fh.org, phone (202)-547-0560. Tom Davis, Director of Health Programs, tom.davis@fh.org, and Emma Hernandez, Child Survival Manager FH/Moz, ehernandez@fhi.net were also actively involved in the writing of the DIP. The MOH and partner organizations were involved in the preparation of this document through their active participation in the start-up, KPC Analysis, and DIP workshops, and we appreciate the support that they are giving to this program.

2 Berhane, Y & Tesfaye F. (Sept. 2001). Food for the Hungry International / Mozambique Health/Nutrition Program Final Evaluation Report.

3 Anbarasi Edward, World Relief. Personal communication regarding pending report on joint FH/World Relief Mortality Study in Gaza and Sofala Provinces, Mozambique (funded by CORE). (November 2004).

B. CSHGP Data Form

Child Survival and Health Grants Program Project Summary

Apr-14-2006

Food For The Hungry, International(Mozambique)

General Project Information:

Cooperative Agreement Number:
Project Grant Cycle:
Project Dates:
Project Type:

GHS-A-00-05-00014 21 (9/30/2005 - 9/30/2010) Expanded Impact

FH Headquarters Technical Backstop: Lauren Erickson
Field Program Manager: Emma Hernandez
Midterm Evaluator:
Final Evaluator:
USAID Mission Contact: Abuchahama Saifodine

Field Program Manager Information:

Name: Emma Hernandez Address: Rue Martires de Massangano, No. 557
Beira **Phone:** 258 23 320 595 **Fax:** 258 23 320 587 **E-mail:** ehernandez@fhi.net

Alternate Field Contact:

Name: Carolyn Wetzel Address: Rue Martires de Massangano, No. 557
Beira **Phone:** 258 23 320 595 **Fax:** 258 23 320 587 **E-mail:** cwetzel@fhi.net

Funding Information:

USAID Funding:(US $): $2,499,910 **PVO match:(US $)** $847,653

Project Information:

Description:

Mozambique ranks 168th out of 177 countries in terms of poverty (2005 UNDP Human Development Report) and currently 70% of the population of Sofala province lives on less than $1 per day. The under-five mortality rate (U5MR) for Sofala is 205 compared with 178 nationally and the infant mortality rate (IMR) is 149 (cf: 124 nationally). In addition, 42.3% of children 0-59m of age in Sofala province are stunted (HAZ<-2); 7.6% are wasted (WHZ<-2); and 26.2% are underweight (WAZ<-2). Forty-four percent of all deaths in Mozambique are malnutrition related. Maternal nutritional practices in Sofala are poor. The percentage of children exclusively breastfed in project districts is only 17%. Feeding frequency and nutrient-density of foods given to children are both problematic. Only one-third of children in project districts (9-23m of age) receive three or more feedings per day apart from breastfeeding. Behavior related to diarrhea is also quite poor: while 90% of mothers in project districts have heard about ORS, only 44 % of mothers can correctly prepare ORS from packets.

To improve the health and nutritional status of children in Sofala, Food for the Hungry (FH) will implement a five-year (October 1, 2005- September 31, 2010) $3.3 million , Expanded Impact Child Survival Project utilizing the Care Group (CG) model.

This project will expand FH's successful Care Group model into ten districts in Sofala province. The CG methodology helps mothers to learn how to help their children survive and thrive, and to adopt new behaviors. In FH's methodology, an initial census is done to divide households with children under two years of age or pregnant women into groups of twelve. Each twelve-household group elects a LM under the guidance of the Promoter. A group of 14 LMs forms a Care Group. Each Promoter serves five Care Groups, and meets with the LMs in each Care Group every two weeks for two hours. During Care Group meetings, Promoters teach LMs weekly health messages using small flipcharts and other educational materials and methods. LMs discuss the health lesson, report on illnesses of children in the households they serve, discuss problem cases (e.g., in terms of behavior change), and report on vital events. LMs practice health promotion in pairs, and are supervised and coached by the Promoter. During the two weeks between Care Group meetings, each of the 4,830 LMs does health promotion through home visits to each of the twelve women/mothers that she serves

(households with pregnant women or children under two). Children 24-59m of age are seen every six months and receive vitamin A, deworming drugs, and are screened for malnutrition.

Complimenting the work that has already been carried out by the MOH and other partners in clinical IMCI, all 69 Promoters and one Leader Mother per Care Group (345) will receive training in community and household IMCI, and learn to assess, classify, refer, and provide advice on home management to mothers in the communities where they work. FH and its partners in Sofala will jointly conduct training and supervision of Promoters to ensure that the partners can continue maintaining the structure once the project has ended.

FH has demonstrated this model to have a positive impact on malnutrition, mortality and results-level indicators of preschool children in Mozambique, as well as changes in maternal morbidity. During the period 1998 to 2001, FH/M decreased malnutrition by 40% (from 50.4% to 30.3%, p The goals of this expanded impact program are to (1) significantly reduce morbidity and mortality – especially among children 0-23m of age and pregnant women – in Sofala province; (2) increase access to community and household IMCI-trained health providers in the program areas; and (3) to transfer the knowledge, skills, tools, and passion needed for effective and sustainable community health development through the Care Group model to project partners – including Leader Mothers – in order to continue child survival activities once this project has ended. FH estimates the beneficiary population to be 198,594 people. This included 21,521 pregnant women, 42,927 mothers of young children, and 134,146 children: 26,829 infants FH will achieve these goals in partnership with the Sofala provincial MOH, the Provincial Women's Committee for Social Action and Coordination (PWCSA), Health Alliance International (HAI), and Doctors with Africa (CUAMM), with whom we have collaborated closely in the development of this plan. The Care Group model will be the chief means of implementing interventions for nutrition and diarrhea, integrated through the household and community IMCI strategy throughout the ten districts of Sofala province. The nutrition intervention will receive 70% of the project effort, and control of diarrheal disease will receive the remaining 30% of effort. To accomplish this, 69 Promoters and 4,830 Leader Mothers working through 345 Care Groups will be trained and operating in Beira, Buzi, Caia, Chemba, Chibabava, Dondo, Gorongosa, Nhamatanda, Maringue and Marromeu districts.

This program has been thoroughly discussed with both Dr. Abuchahama Saifodine, the Acting Team Leader of the Office of HPN and Titus Angi, Health, Population and Nutrition Specialist, both with the USAID mission in Mozambique. The main writer of this DIP document was: Lauren Erickson-Mamane, Child Survival and Nutrition Program Coordinator, Food for the Hungry, 236 Massachusetts Ave., NE Suite 305, Washington DC 20002,

lauren.erickson@fh.org, phone (202)-547-0560. Tom Davis, Director of Health Programs, tom.davis@fh.org, and Emma Hernandez, Child Survival Manager FH/Moz, ehernandez@fhi.net were also actively involved in the writing of the DIP. The MOH and partner organizations were involved in the preparation of this document through their active participation in the start-up, KPC Analysis, and DIP workshops, and we appreciate the support that they are giving to this program

Location:

Ten districts in Sofala Province: Beira, Buzi, Caia, Chemba, Chibabava, Dondo, Gorongosa, Nhamatanda, Maringue and Marromeu districts.

Project Partners	Partner Type	Subgrant Amount
District level MOH offices	Collaborating Partner	
CUAMM	Collaborating Partner	
HAI	Collaborating Partner	
PWCSA	Collaborating Partner	
AISPO	Collaborating Partner	

General Strategies Planned:

(None Selected)

M&E Assessment Strategies:

KPC Survey Lot Quality Assurance Sampling Community-based Monitoring Techniques

Behavior Change & Communication (BCC) Strategies:

Interpersonal Communication Peer Communication

Groups targeted for Capacity Building:

PVO	Non-Govt Partners	Other Private Sector	Govt	Community
Field Office HQ CS Project Team	PVOs (Int'l./US)	(None Selected)	National MOH Dist. Health System	CHWs

Interventions/Program Components:

Nutrition (70 %)

(IMCI Integration) (CHW Training)
-Comp. Feed. from 6 mos.
-Hearth
-Cont. BF up to 24 mos.
-Growth Monitoring
-Maternal Nutrition

Control of Diarrheal Diseases (30 %)

(IMCI Integration) (CHW Training)
-Hand Washing
-ORS/Home Fluids
-Feeding/Breastfeeding
-Care Seeking
-Case Mngmnt./Counseling
-POU Treatment of water

Target Beneficiaries:

Infants < 12 months:	**26,829**
Children 12-23 months:	**26,829**
Children 0-23 months:	**53,658**
Children 24-59 months:	**80,488**
Children 0-59 Months	**134,146**
Women 15-49 years:	**64,448**
Population of Target Area:	**1,076,055**

Rapid Catch Indicators:

Indicator	Numerator	Denominator	Percentage	Confidence Interval
Percentage of children age 0-23 months who are underweight (-2 SD from the median weight-for-age, according to the WHO/NCHS reference population)	**146**	**557**	**26.2%**	**3.7**
Percentage of children age 0-23 months who were born at least 24 months after the previous surviving child	**54**	**91**	**59.3%**	**10.1**
Percentage of children age 0-23 months whose births were attended by skilled health personnel	**103**	**199**	**51.8%**	**6.9**
Percentage of mothers of children age 0-23 months who received at least two tetanus toxoid injections before the birth of their youngest child	**94**	**199**	**47.2%**	**6.9**
Percentage of infants age 0-5 months who were exclusively breastfed in the last 24 hours	**9**	**52**	**17.3%**	**10.3**
Percentage of infants age 6-9 months receiving breastmilk and complementary foods	**24**	**30**	**80.0%**	**14.3**
Percentage of children age 12-23 months who are fully vaccinated (against the five vaccine-preventable diseases) before the first birthday	**73**	**91**	**80.2%**	**8.2**

Percentage of children age 12-23 months who received a measles vaccine	**75**	**100**	**75.0%**	**8.5**
Percentage of children age 0-23 months who slept under an insecticide-treated bednet the previous night (in malaria-risk areas only)	**69**	**199**	**34.7%**	**6.6**
Percentage of mothers who know at least two signs of childhood illness that indicate the need for treatment	**149**	**199**	**74.9%**	**6.0**
Percentage of sick children age 0-23 months who received increased fluids and continued feeding during an illness in the past two weeks	**13**	**167**	**7.8%**	**4.1**
Percentage of mothers of children age 0-23 months who cite at least two known ways of reducing the risk of HIV infection	**69**	**199**	**34.7%**	**6.6**
Percentage of mothers of children age 0-23 months who wash their hands with soap/ash before food preparation, before feeding children, after defecation, and after attending to a child who has defecated	**2**	**199**	**1.0%**	**1.4**

Comments for Rapid Catch Indicators

C. Description of DIP Preparation Process

The DIP preparation process was participatory and included Food for the Hungry headquarters staff, program staff from Food for the Hungry/Mozambique, district and provincial representatives from the Mozambican Ministry of Health, representatives from our partner organizations and the USAID/Mission in Maputo. A full list of the names of participants and their organizations can be found in Annex 8.

In December 2005, FHUS Director of Health Programs, Tom Davis, and CS backstop Lauren Erickson-Mamane, conducted a CSGHP Start-up Workshop in Beira, Mozambique that included FH HQ and field staff, four district level MOH representatives and representatives from HAI, CUAMM, Salvation Army, and PWCSA,. The workshop introduced participants to the CSHGP and reporting requirements, discussed Food for the Hungry's programs in Mozambique, and provided an overview of the expanded impact program including project areas, program objectives and indicators, and interventions. Participants also discussed how to involve the MOH, Church, and other partners to take the CG structure to scale. Lastly project participants worked to develop the year one implementation plan. Immediately after the workshop, Tom Davis, Lauren Erickson-Mamane, Emma Hernandez, CS Program Manager FH/Moz, and Carolyn Wetzel, FH/Moz Health and Nutrition Manager, traveled to Maputo to meet with Doctors Abuchahama Saifodine and Titus Angi with the USAID/Mission to discuss the results of the start up workshop, revisions to the original project proposal, and how to best collaborate with the mission during program implementation. Meetings to discuss program collaboration were also held with the WHO and UNICEF.

Following the start up workshop, project staff worked with community leaders in conducting community mapping, census and retrospective mortality study activities in our 10 program districts. Furthermore, program Promoters were hired, Leader Mothers were selected and Care Groups were formed.

Prior to the beginning of the project (in January 2005), FH/Mozambique carried out an expanded local determinants of malnutrition study in Sofala province. (Results are in the baseline assessments report.) Beginning in February 2006, qualitative and quantitative baseline data was collected via a KCP (Knowledge, Practice and Coverage) survey, using Lot Quality Assurance Sampling (LQAS), and focus groups. A DIP workshop and KPC Analysis workshop were conducted from March 6 – 17, 2006 by Tom Davis and Lauren Erickson-Mamane in order to analyze KPC data, compare data to other data sources (e.g., the DHS), refine project indicators, revise program strategies, interventions and activities, review MOH norms and policies, develop a plan for presenting baseline assessment data to project communities and stakeholders, and revise the program budget. The participants included field staff, district level MOH representatives, and representatives from all partner organizations. In March, Lauren Erickson-Mamane and Emma Hernandez also met further with representatives from each PVO/NGO partner organization (HAI, CUAMM, AISPO, and PWCSA) as well as National, Provincial and District MOH staff to discuss the project, seek their input, and obtain local agreement and

support for the project.

National, provincial and districts MOH offices have given their full support to this program and will work closely with project staff in supervising Care Groups, conducting IMCI training, participating in Care Group Module trainings, as well as providing project Promoters and Leader Mothers with Vitamin A, ORS packets, Iron supplements, and Mebendazole/Albendazaole (as Match). A memorandum of understanding (MOU) was presented to the National MOH but as of the submission of this DIP has not been signed. FH has been in close contact with the MOH during the elaboration of this DIP and anticipates receiving the signed MOU in the near future. FH currently has a verbal agreement with the Provincial MOH office and a letter of support (which was submitted with the proposal).

On March 24, 2006 CS Program Manager, Emma Hernandez, met with Dr. Titus Angi of the USAID/Mission to further elaborate collaboration with the mission; to discuss IMCI protocols, zinc supplementation, and securing agreements with the National MOH offices; and to meet key nutrition program contacts at the mission. In the weeks following this visit, FH/Moz field staff has been in close communication with the USAID mission in Mozambique concerning this DIP. The mission has offered to facilitate the MOU process with the National MOH and to assist in locating training materials for C-IMCI (which should be updated and released very soon).

Ms. Hernandez also discussed program collaboration with people from Chemonics who are currently implementing a five- year technical assistance project with assistance from USAID called FORTE Saude. This program works with the Ministry of Health primarily at the Central level. While they are open to collaborating with PVO's when serving the same beneficiaries, Chemonics is not currently operating in Sofala province.

D. Revisions (from the original application)

Changes in Project Sites:

The original expanded impact project proposal, submitted by Food for the Hungry in November 2004, stated that the program would operate in five districts of Sofala province and an additional four districts in Zambezia province. After careful consideration, FH increased the number of districts served in Sofala province as opposed to expanding our activities into the province of Zambezia in year three of the program. The various reasons for this modification are outlined below:

Poor health status of Sofala
The current health situation of Sofala is alarming and data demonstrates that this province is in worse shape than Zambezia. The DHS indicated that the infant mortality rate in Sofala is 149 as compared with 89 in Zambezia. Sofala's U5MR is 205 but only 123 in Zambezia and the HIV prevalence rate in Sofala is 26.5% compared with 18.4% in Zambezia. Furthermore, Sofala province has been the hardest hit by recent Cholera outbreaks. Therefore, by increasing the number of districts in Sofala province, Food for

the Hungry will have a greater impact upon the health status of the children reached by the project.

Greater potential for scaling-up
By increasing the number of target communities in one province, Sofala, FH will be better poised for demonstrating the results of taking the Care Group model to scale. Through demonstrated success in many districts of Sofala, as opposed to smaller numbers of communities in both Sofala and Zambezia provinces, FH will be better positioned to affect province-wide indicators and demonstrate success to the provincial and national MOH and other stakeholders. This will also better position FH to advocate for taking the Care Group model to scale in other provinces and nationally. FH's numerous contacts with MOH counterparts in Sofala will hopefully strengthen the Sofala health system such that it has the capacity to carry out the Care Group Model at scale.

Greater efficiency
By working in only one province, FH will be able to avoid costs associated with setting up a provincial office in Zambezia province. FH should also be better able to maintain communications and assure regular supervision by working in a single province.

Overlap of organizations in Zambezia Province
World Vision is now implementing a child health program coving 50% of the population in three of the four districts of Zambezia in which FH proposed to implement the Expanded Impact program. When the proposal was written, staff members of WV in Mozambique approved of Food for the Hungry working in these districts. With the hope of extending and expanding their program in 2008, World Visions has changed its plans (since the proposal was written) and is no longer in favor of FH working in Zambezia province.

Given the likelihood of greatly improving the health status of the population of Sofala, and in an attempt to influence national health policy, the districts in which FH will implement the Expanded Impact program are:

Years 1-5	**Caia** (50% of population)
	Chemba
	Meringue
	Marromeu (50% of population)
	Beira (a portion of this district)
Years 2.5-5	**Dondo**
	Gorongosa (50% of the population)
	Nhamatanda (50% of the population)
	Chibabava
	Buzi

In the proposal, FH planned to reach 126,149 preschool children and 29,509 pregnant women, for a total of 155,658 beneficiaries. With this new plan, 21,521 pregnant women and 134,146 children will be reached for a total of 155,667 beneficiaries. Per approval

from USAID, FH will also include the beneficiary mothers of children aged 0-23 months in its total beneficiary calculations. This program will reach 42,927 mothers of young children, therefore bringing the total number of program beneficiaries to **198,594**. Two beneficiary tables are provided in **Annex 9 & 10.**

The modifications in program sites were done with the support of both the USAID Mission and the Provincial MOH.

Changes in Program Description:

One of the primary goals of this program is to transfer the knowledge, skills, tools and passion needed for effective and sustainable community health development through the Care Group model to project partners in order to continue child survival activities and maintain results once the project has ended. In order to facilitate taking this model to scale, and to convince the MOH of its effectiveness and efficiency, we made some adjustments to the model. Lead Mothers will now visit fewer households, visiting twelve as opposed to the original 14 households. To compensate, we will have 14 Leader Mothers (as opposed to 12) meet in each Care Group. (This is closer to the original [successful] model used in Title II where LMs each visited 10 households.) To reduce the amount of traveling required of our Promoters, we have decided to employ 64% more Promoters. FH will employ 30 Promoters in Phase I of the program, and in Phase II, an additional 39 Promoters will be hired. Each Promoter is now responsible for supervising five Care Groups as opposed to ten which will reduce their travel times, and allow them to spend more time in each community. Therefore with a total of 69 Promoters, and 345 Care Groups, the program will continue to reach a total of 57,960 households.

FH originally proposed conducting monthly GM/P post for children 0-23 months of age and screening for malnutrition every six months for children 24-59m of age. Based on concerns raised by the MOH and our partner, HAI, FH has had to re-evaluate its GM/P strategy. The MOH and HAI were concerned that FH's community-based GM/P posts would reduce the number of mothers and children visiting health facilities. (The percentage of children 0-23 months receiving growth monitoring during the four months preceding the baseline survey in Feb 2006 was 70%.) When mothers bring their children to the health facility for weighing, the MOH capitalizes on these visits to assure delivery of other health services including immunizations, vitamin A supplementation, and other services. During preparation of the proposal, our GM/P strategy was shared with the provincial MOH and no concerns were raised. However during the DIP preparation process, we discovered that the MOH would no longer approve of FH staff and LM's writing on the MOH growth cards and they raised concerns regarding community level weighings. Therefore, during the DIP workshop, FH worked with the MOH and partners to develop a strategy that would satisfy all program partners. The new strategy allows the MOH to continue to weigh children at health facilities, but gains more involvement of Leader Mothers in the most important part of GM/P: nutritional counseling. During nutritional counseling, LMs will still ask open and closed-ended questions in order to discover current feeding and illness history. Answers will still be documented on a "behavior box" which is kept with the child's growth chart, and will serve as a cue to the

Promoters and Leader Mothers so that counseling is tailored to each child's specific dietary and illness situation.

Leader Mothers and Promoters will encourage mothers to attend the MOH monthly GM/P post and track attendance and weight loss or gain via the CG registries (using the child's growth chart). The district MOH representatives have agreed that the GM/P sessions conducted at health facilities do not provide adequate time for counseling of mothers. Therefore, to the greatest extent possible, Leader Mothers will accompany their beneficiary mothers (as a group) to GM/P sessions held at the health facilities each month. Leader Mothers will then provide counseling to mothers after the MOH conducts child weighings, either at the health facility or once they have returned to their home communities. Leader Mothers will be trained to read and interpret MOH Growth Cards so that they can conduct additional counseling during their weekly home visits. Leader Mothers will continue to use the "behavior box" but instead of a sticker adhered to the growth card, this will be a separate card that the LM's will maintain for the children of her beneficiary mothers. FH will continue to weigh children (aged 0-59mths) every six months during screening for the Hearth rehabilitation program.

As part of annual mini-KPC surveys, FH will collect data regarding the number of children weighed during the past three months. If FH finds that the number of children being weighed each month is not increasing, this data will be used to again build a case for doing GM/P at the community level. Each Care Group will have a low-cost child scale (purchased from UNICEF) which will be used for demonstrations, during semi-annual screenings, and to weigh children during months when it is impossible to reach health facilities (e.g., due to impassable roads in the rainy season).

Changes in Management Plan:

Due to budgetary constraints on the part of ESMABAMA, this Catholic Health Project will no longer be partnering with FH in the implementation of field activities. A new partnership has been forged with Doctors with Africa, CUAMM who will be responsible for providing treatment of severely malnourished children in Manga and Beira. CUAMM operates a feeding center in Beira. FH will also continue to partner with the MOH, HAI, PWCSA, AISPO and others.

Lauren Erickson-Mamane, MPH, FH's Child Survival and Nutrition Programs Coordinator, will serve as the primary technical and administrative backstop to the field staff in Mozambique. She will devote 42% of her time to the project during year 1 (up from 35%) and 35% thereafter. Ms. Erickson-Mamane was hired by FH in September 2005 and was approved as FH's CSHGP backstop by USAID/Washington in October 2005. Ms. Erickson-Mamane has over 6 years of international development experience managing maternal and child health programs. Tom Davis, MPH, FH's Director of Health Programs, will continue to backstop this program and will allocate 38% of his time (up from 30%) during year 1 and 30% thereafter. Mr. Davis has worked with CORE and 18 PVO's in the child survival community for 18 of the past 21 years. Mr. Davis has been integrally involved with the management of the Care Groups projects in

Mozambique for the last six years and has presented on the model at CORE, APHA and other scientific meeting. Ms. Erickson-Mamane and Mr. Davis will travel to Mozambique approximately two-three times per year. Emma Hernandez Avilan, BSN, is the Child Survival Program Manger in Mozambique. Ms. Hernandez has ten years experience in training health workers during in Angola and she is therefore fluent in Portuguese. Her expertise includes organizing, planning, training, and managing community health programs with emphasis on Maternal and Child Health. She received USAID approval as key personnel in October 2005.

Due to the significant number of trainings that FH will provide to project staff, Leader Mothers and our partners, we have added a trainer position. The Trainer will work with the CSP manager and HQ staff in the finalization of Care Group modules and in conducting program trainings. S/he has yet to be hired, but will devote 100% of his/her time to this program.

Changes in Budget:

While there has been very little change to the overall budget totals, line item additions and reallocating of costs within several budget categories was needed to more realistically reflect program implementation (i.e. the number of Promoters needed for our 10 districts, addition of a trainer position, as well as providing for international travel of our FH/M Child Survival Program Manager to the CSHPG Mini-University in June). A **revised budget and narrative are included in Section 9**.

E. Detailed Implementation Plan

1. Program Site Information

a. This project will expand the Care Group network to new communities in ten districts in Sofala province - Beira, Buzi, Caia, Chemba, Chibabava, Dondo, Gorongosa, Nhamatanda, Maringue and Marromeu. Detailed maps, including location of health facilities in each of our ten district program impact areas, can be found in **Annex 2.**

Project Area: District	Total Population Served					Calculated Children	Calculated Pregnant Women	Mothers of children 0-23 mths	Total Beneficiaries
	Year 1 (2005)	Year 2	Year 3	Year 4	Year 5				
Caia (Sofala), 50%	49,371	51,000	52,683	54,407	56,202	9,442	1,124	3,021	10,566
Chemba	42,301	43,697	45,139	46,615	48,154	8,090	963	2,589	9,053
Maringue	64,565	66,696	68,897	71,150	73,498	12,348	1,470	3,951	13,818
Marromeu (Sofala), 34%	31,725	32,763	33,844	34,951	36,105	6,066	722	1,941	6,788
Beira (Portion of pop. only)	105,854	109,347	112,956	116,650	120,500	20,244	2,410	6,478	22,654
Dondo, 50%			167,834	173,373	179,094	15,044	1,791	4,814	16,835
Gorongosa, 50%			89,475	92,428	95,478	8,020	955	2,566	8,975
Nhamatanda, 50%			191,027	197,331	203,843	17,123	2,038	5,479	19,161
Chibabava			66,904	69,112	71,393	11,994	1,428	3,838	13,422
Buzi			179,732	185,663	191,790	25,777	3,069	8,248	28,845
Total	**293,816**	**303,503**	**1,008,491**	**1,041,680**	**1,076,055**	**134,146**	**21,521**	**42,927**	**198,594**

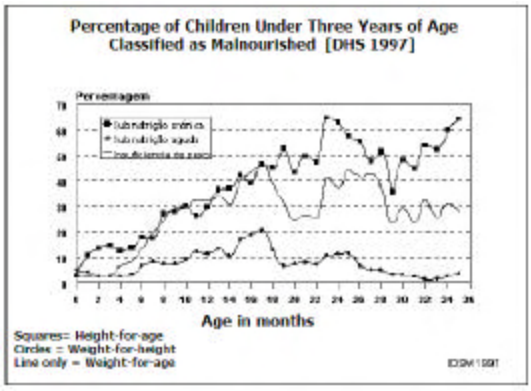
b. The total population living in the project site is estimated to be **1,076,055** based on district population figures supplied by the Mozambican MOH. FH estimates the **beneficiary population to be 198,594 people.** This includes 21,521 pregnant women, 42,927 mothers of young children, and 134,146 children: 26,829 infants <12mths, 26,829 children 12-23 mths, and 80,488 children 24-59 mths.

c. Health status of the population:

Mozambique is a **Global Health priority country** for maternal and child health for good reason. According to the 2003 DHS, Sofala province's under-five mortality rate is 205 [cf: 178 nationally], the infant mortality rate is 149 [cf: 124 nationally], and the neonatal mortality rate is 40 per 1,000 live births. The chief reason for this staggering mortality rate is Mozambique's high levels of poverty, malnutrition, and lack of health services, especially community-level health promotion. **Less than 40 percent of Mozambicans have access to health care.** Health data for Sofala province show malaria, diarrheal diseases, and measles as the most commonly reported childhood illnesses. (Pneumonia is also a cause of childhood illness, but less so than most areas of the country.) MOH staff in Sofala believe that the five top causes of child deaths are the same as the five top causes of admission to the pediatric ward in provincial health facilities: malaria, malnutrition, anemia, diarrhea (including cholera), and pneumonia. The case fatality rate for malnutrition is alarmingly high at 20.9%, and will be addressed in this project through a Hearth nutritional rehabilitation program. Also, through FH's Title II program, MOH health facility staff in Sofala will have access this year to state-of-the-art training on management of severe malnutrition.

A retrospective mortality study, conducted as part of the baseline assessment, found that 43% of the deaths recorded in the project area were mentioned in association with fever, 31% with diarrhea, 19% associated with not eating (malnutrition), 21% with ARI, and 17% with other symptoms. It is likely that malnutrition affected about 44% of these deaths but parents do not always note that as a symptom. **Furthermore, 90% of the deaths of preschool children discovered in this study were in the 0-23 month old age group.** Our baseline survey found that 86% of children aged 0-23 months slept under a net the previous night. However, only 36% of these nets were ever treated. (We were told during the KPC analysis workshop that it is possible that some of these nets were long lasting insecticide impregnated nets – LLIN) FH will focus more discussion during the IMCI Care Group Modules on treating fever, early care seeking for fever, and malaria prevention. We will also be seeking additional funding (eventually) through the President's Malaria Initiative and other sources to add a full malaria intervention to this Care Group project.

FH's baseline survey found that 26% of children in project districts aged 0-23 months of age were underweight (WAZ<-2.0). The 2003 DHS found that forty two percent (42.3%) of children under five years of age in Sofala province were chronically malnourished (cf: 36% nationally), 26% were underweight, and 7.6% were wasted. Acute malnutrition (wasting) increases from about 5 to 17 months of age to a peak of 20% and then decreases (improves).[4] At least 5% of the children born in Sofala from 1994-97 had low birth weights (<2500 grams), and 26.5% were smaller than the median [cf: 18.5% nationally]. **Forty-four percent of all under-five deaths in Mozambique are malnutrition related.** [DHS, 2003]



Infectious diseases are common, especially diarrhea. A cholera emergency was declared by the Ministry of Health on January 9th 2004.[5] Service statistics found fever in 39.5% of children in Sofala [cf: 44% nationally], with the main cause being malaria. In all of Sofala, 19% of children were found to have diarrhea in the past two weeks, but only 5% of children were found to have cough with difficulty breathing [DHS 2003], the lowest rate in the country. Childhood immunization in Sofala province is relatively good. The KPC found that 80% of children 12-23m of age are fully immunized, higher than the national average of 63%. From testing of women attending antenatal care, the HIV/AIDS prevalence has been estimated to be 26.5% as of 2002.[6] Beira's sentinel post had the highest recorded prevalence of HIV/AIDS in the country, and data from sentinel sites in

[4] Mozambique DHS (2003).
[5] http://www.who.int/csr/don/2004_03_23/en/index.html
[6] Report on Epidemiological Surveillance Data on HIV, 2002 [Relatorio sobre a Revisao os Dados de Vigilancia Epidemiologica do HIV – Ronda 2002]. (November 6, 2003). Mozambican MOH, National Program for Control of STDs and HIV/AIDS. Maputo.

Sofala show an increase from 21% to 26.5% between 2001 to 2002.

These statistics are generally better than the results found through of our baseline survey which found that 40% of children in our project area had diarrhea in the two weeks preceding the survey (which was conducted during diarrhea season). ,71% of children aged 0-23 months with diarrhea received ORS and/or recommended home fluids (RHF), but only 44% of mothers knew how to correctly prepare ORS. 80% of children 12-23 months in our baseline were fully vaccinated before their first birthday.

Water and sanitation practices in the project districts were found to be quite poor. 45% of households get their water from springs, rivers, or streams, 21% from public wells, and 17% from lakes, ponds, or dams. Only 41% of respondents purified the water that they gave to their child (i.e., the index child) using an effective method. The last time they defecated, 77% of children defecated in a cloth or washable diaper and 7% defecated outside of the house on the ground (but not in a hole dug for that purpose). 41% of mothers of infants[7] claimed to have a special place to wash their hands, but only 4% had everything required. When asked when they wash their hands, only 1% of mothers mentioned the four correct times.

Mozambique has one of the highest maternal mortality rates in the world at 1,000 per 100,000.[8] The most common problems during pregnancy are prolonged labor, hemorrhage, postpartum infection, and hypertension. In 31% of the neonatal deaths registered, prolonged labor was a factor. [DHS, 1997] The most common causes of maternal death in Sofala are obstructed labor, hemorrhage, sepsis, and eclampsia/ pre-eclampsia, and only 50% of births were assisted by a health professional [cf: 45% nationally]. [DHS, 2003]

d. Describe other factors that influence health

According to the 2005 UNDP World Development Report, **Mozambique ranks 168th out of 177 countries in terms of poverty, and the incidence of poverty at the provincial level is most marked in Sofala Province** where 70% of the population lives on less than $1 per day [cf: 38% nationally].[9] The prevalence of destitution is the highest in Sofala where 88% of the population lives in absolute poverty. Eighty-five percent of the population of Sofala does not have access to potable water,[10] and population density is 22 people per square km. The **major source of livelihood** in Sofala province is subsistence agriculture characterized by smallholdings and traditional farming. The **cultural groups** in Sofala province are the *Sena* (86% of population) and *Ndau* (3%) peoples who each have their own indigenous language, while 23% speak Portuguese, as well. Half of the population in Mozambique hold indigenous beliefs, 30% are Christian,

---

[7] Questions on hygiene were only asked of mothers of infants in order to keep the questionnaire a reasonable length.

[8] UNICEF State of the World's Children Report. (2005).

[9] UNDP Reports. (1998, 2000, 2001).

[10] Action Plan for the Reduction of Absolute Poverty (2001-2005) - Republic of Mozambique. Government of Mozambique. See the International Labour Office webpage at http://www.logos-net.net/ilo/150_base/en/init/moz_2.htm#Table%202.2

and 20% are Muslim. **Gender divisions** are striking in Mozambique. The gender gap in primary school enrollment is twice as bad in Mozambique as that of sub-Saharan Africa as a whole,[11] and 75% of women vs. 58% of men and women over the age of 15 in Sofala Province are illiterate.[12]

Cultural beliefs affect health practices as many Mozambicans prefer traditional healers to trained medical professional. During recent focus groups in Sofala, mothers and community leaders stated that they sometimes prefer traditional healers because of their affordability and their "capacity to minister treatment through spirits." It was also stated that the spirit of a child's grandparent is used to examine a patient. The types of illnesses for which communities acknowledged they turn to traditional healers included fever, malaria, cholera, diarrhea, measles, asthma, anemia and convulsions as well as "bad spirits." It should be noted, however, that only 10% of respondents in the KPC survey said that they went to a traditional healer the list time their child was ill. Bad spirits are often blamed when a child prefers to eat sand, has anemia, malnutrition or convulsions.

e. **Discuss the current status and overall quality of health care services**

For a population of 1.6 million, the MOH has 1,154 technical health staff members, or about 1,387 people per trained public health worker. These resources, however, are not distributed in an equitable manner and many parts of rural areas are very far from health facilities. The 2003 DHS estimated **that less that 40% of Mozambicans have access to health care.** Costs for health services at MOH health facilities are minimal, but patients usually need to buy medications from private pharmacies since MOH facilities often lack medications. The technical areas currently prioritized by the MOH are **maternal health, IMCI, and nutrition.** The scarcity of health facilities sometimes leads people to use traditional healers, drug vendors, and other informal health care providers as their first-line health care providers. The KPC survey found that 51% of mothers with a child that had been ill in the past two weeks sought treatment outside their home, and about 75% of those sought treatment at a health facility.

During the preparation of the DIP, FH consulted with MOH representatives to collect information concerning health resources by program intervention district. The results of that information are as follows:

PHASE I Districts	**Beira**	**Maringue**	**Marromeu**	**Caia**	**Chemba**
Hospitals (number and staffing):	1 (no info on staff)	0	1 (50 staff)	0	1 (44 staff)
Health Centers (number and staffing):	8 (296 total staff) + 1 Center for Cholera	4 (31 staff) * no doctor	4 (no info)	8 (39 total staff)	5 (3 staff for each center)
Health Posts (number and staffing:	3 (13 staff)	2 (3 staff for each)	1 (1 nurse)	7 (7 Agents each)	8 (no info)
Private health facilities and staffing:	14	0	1 (Sena Sugar Company)	0	0
Plans for new health facilities	1 General	Plans are centralized	1 district Hospital	2 health centers	6 health centers

[11] World Bank Summary Gender Profile for Mozambique. (See http://www.worldbank.org/afr/gender/mozambique.pdf).

[12] Action Plan for the Reduction of Absolute Poverty (2001-2005). (See endnote #12 above.)

(public or private) over next five years:	Hospital 1 Health Center			-transform current HC in Sena to type I HC. Caia to Rural Hospital	1 out-patient block under construction.
Plans for new staffing over next five years:	Plans are centralized	Plans are centralized	Plans are centralized	Plans are centralized	4 SMI nurses* 4 nurses 1 Preventive medicine
NGOs and PVOs currently working the district	CUAMM, Aro Moç. Ajups, Red Cross, Care for Life, ADC, Lekaa Gona, FHI.	FHI; good relationship	FHI, HAI	FHI, AISPO,HAI, Consorcio.	None
Socorristas and any other community-level staff currently in the district (number and location):	Aro Moçambique 16 activists	5 Socorristas from Moz. Red Cross are working in Palame, Nhamunho, Chionde, Nhangarar & Fudza.	6 – Ilha Inglesa, Kanámua, Macuere, Safrique, Kúndue and Nhaminjale.	Is difficult to supply this data.	8- Nhandula, Quarenta, Xavier, Correia, Nhamaliwa & Bangue.
Staff trained in IMCI case management (clinical or community IMCI Protocols):	54 nurses SMI	2 SMI nurses 2 General Medicine technicians	12	15 staff	All Nurses, all technical staff
PHASE II Districts	**Nhamatanda**	**Gorongosa**	**Buzi**	**Dondo**	**Chibabava**
Hospitals (number and staffing):	1	0	1	0	1
Health Centers (number and staffing):	10 (95)	10 (34)	10 (55)	6 (78)	10 (61)
Health Posts (number and staffing:	6	6	11	6	1
Private health facilities and staffing:					
Plans for new health facilities (public or private) over next five years:		Plans are centralized	Plans are centralized	Plans are centralized	Plan are centralized.
Plans for new staffing over next five years:	Plans are centralized	Plans are centralized	Plans are centralized	Plans are centralized	Plans are centralized
NGOs and PVOs currently working the district	FHI, Moz red.HAIcross	FHI,Red Cross, HAI	Cuamm, Aro Moç. Ajups, Red Cross, Care for Life, ADC, Lekaa Gona, FHI.	FHI, AISPO,HAI, Consorcio.	0
Socorristas and any other community-level staff currently in the district (number and location):	Aro Moçambique 16 activists	Mozambican Red Cross has 50 activistas	.	? Activistas	8 socorristas.
Staff trained in IMCI case management (clinical or community IMCI protocols):	10 Nurses IMCI	10 Nurses	5 Tecnicos	All Technical Staff	All Nurses, all technical staff

Regarding **availability of drugs** - the MOH stated that they have unlimited supplies of **ORS** and stock outs never occur at the health clinics. The MOH will be supplying FH Promoters and LMs with ORS for community level distribution. **Vitamin A** is considered an essential medicine and is supplied by a central office called MEDIMOC. Stock outs do occur, the frequency of which varies from district to district depending on road conditions. The MOH, and the PVO Sight for Life, will supply FH with Vitamin A for community level distribution. The availability of **Iron tablets** is like that of ORS, a very good supply; however the supplement does not contain folic acid. The MOH policy is to provide iron supplements to all pregnant women during antenatal visits, however they are uncertain as to what percentage of pregnant women comes to the health facilities. Due to a recent change in the malaria protocol from Chloroquine to Fansidar (due to resistance), the MOH now uses Fansidar for Malaria prophylaxis. The MOH uses

* Maternal Health Nurse

Amoxicillin as its first line antibiotic. They follow IMCI protocols however the IMCI kits that they receive come with Cotrimoxazole. Therefore, there are periodic stock outs of amoxicillin suspension for children. Lastly, the MOH has a school-based program where they provide **Albendazole** to all children 7-10 years of age. In the hospital and clinics, they provide **Mebendazole** only to children who are ill. FH is currently awaiting MOH approval to deworm children >12 months of age at the community level in order to further increase coverage. The baseline KPC found that 24% of children aged 12-23 months were during the past six months (based on mother's report).

Limited community health services (antenatal checks, immunization, vitamin A supplementation, and weighing of children) are offered by the MOH health facilities in each project district every month or two, but mostly in the areas immediately surrounding each health facility. The geographical area that is not covered by these health facilities is supposed to be covered by the hospital, the main clinic in each district, or NGOs. The MOH district teams are currently only able to visit one community each month given budget limitations. The provincial MOH staff visit each district twice a year for supervision. The MOH generally relies on NGOs to provide community health services, especially health promotion.

In Sofala, of the health workers who attend to preschool children in health facilities, 78% have been trained in clinical IMCI. The provincial MOH in Sofala has trained 20 clinical IMCI facilitators and 262 clinical workers in clinical IMCI representing at least one health worker per health clinic and hospital. Of all the staff trained in IMCI, only 26% have received one or more follow-up visits after training. Of those observed during follow-up, 95% asked about the three principle symptoms (cough, diarrhea, and fever), but only 35% evaluated children for general danger signs.[13] A national HFA conducted in Mozambique in 2001 also found problems with the distance to referral facilities, lack of proper materials and drugs, and health worker compliance with IMCI protocols. The MOH will be following up on the IMCI training that has been done in Sofala and improving supervision of health workers trained in clinical IMCI.

Community Leadership Councils have been trained in IMCI in parts of some districts of Sofala by Terre de Hommes (TDH, a Swiss NGO) and HAI, but in general, few community-level workers have received community IMCI training in Sofala and this province **remains largely uncovered by community/HH IMCI at this time.**

Food for the Hungry (FH) and other NGOs presently provide needed community health services in some parts of Sofala. FH is committed to significant improvement in health status of the people of Sofala, and has worked in health in Sofala for the past seven years. **FH is currently operating a Title II health and agriculture program in about 50% of four districts in Sofala Province** (Nhamatanda, Gorongosa, Caia and Marromeu), covering approximately 65,600 beneficiaries. FH's current Title II health interventions are nutrition (including micronutrients and breastfeeding), diarrheal disease control, ARI management, immunization, malaria prevention and control, and HIV/AIDS prevention

[13] IMCI: Implementation Process of the IMCI Strategy in Mozambique 1998-2002. (May 2003). MOH. Maputo.

and control. FH has *significantly* reduced malnutrition and increased healthy behaviors – especially nutrition and diarrhea home management practices – through its use of ***Care Groups*** in the four districts of Sofala included in its Title II project during 1998 to 2002. **The nutrition and diarrhea interventions of this successful project will be scaled up during this project and integrated using community IMCI to reach the ten districts of Sofala province.**

Other private organizations working in health in Sofala include the Catholic Church, and Health Alliance International (HAI). **Health Alliance International (HAI)** is currently administering a CS project (that will be completed in 2007) in four districts of Sofala (Dondo, Nhamatanda, Gorongosa, & Beira). HAI's project in Sofala addresses STI/HIV/AIDS (40%), malaria control (35%) and maternal care (25%). Up until April 2003, the USAID mission funded the work of Terre des Hommes *(TDH)*, a Swiss NGO that worked in 40% of the communities in five districts within Sofala (Nhamatanda, Marromeu, Dondo, Buzi and Chiringoma). *Terre des Hommes* is no longer operational in Sofala, but realized some activities in clinical IMCI, immunization, nutrition, and reproductive health, and funded one nurse in each of the five districts who worked in the district health office. The vast majority of their work was accomplished within the MOH health centers and at immunization posts in some communities.

Doctors with Africa (CUAMM) currently operates a feeding center in Beira, providing rehabilitation of children with severe malnutrition. The Italian Association for Solidarity among People (AISPO) has been working to improve health infrastructure in Caia and Chemba since 1995 (funding for this program will end in May 2006), but they have proposals submitted to continue work in several of the project districts.

The largest **barriers to access to health care** in the Sofala province include (1) the lack of a mechanism to do large-scale health promotion due to the non-existence of CHWs – and little use of volunteers – in the MOH system; (2) the inadequacy of the distribution, number, and staffing of health facilities in rural areas of the province; (3) unavailability and cost of medications and (4) the lack of passable roads during the rainy season and lack of affordable transportation. According to the MOH, it can take community members anywhere from 5-9 hours to reach a district hospital in Sofala. During focus groups discussions participants stated that health posts are located anywhere from a 30 minute to 3 hours walk from their communities and no community health personnel are currently conducting home visits in their communities.

Aside from the economic barriers and lack of geographically-accessible health services, there are also cultural barriers in that some people prefer to use traditional healers before they use health facilities, in part because they are more accessible, less costly, known to communities, and because people believe in their effectiveness.

During recent focus group discussing in Sofala, participants, on average, gave health posts and district hospitals low ratings regarding quality of client-provider interaction. They stated that they were often faced with long waits, insufficient quantities of costly medications, and overworked nurses.

f. Identify any groups in the program site that are considered disadvantaged, at high risk of death, under-served or living in extreme poverty.

Led by economic growth and reduction of absolute poverty, Mozambique experienced a significant reduction (18%) in child mortality between 1997 and 2003. However it still has one of the highest rates in the world and nearly one in five children die before reaching their fifth birthday. The U5MR in Sofala is currently 205 [DHS 2005]. Of an estimated 715,000 children born each year, about 89,000 will die before reaching age one and an additional 39,000 will not reach age five.[14]

A retrospective mortality study conducted during baseline found that 90% of the deaths of preschool children in program districts occurred in the 0-23 month old age group, with 67% of all child deaths occur during the first 12 months of life in the Phase I districts.

The poverty experienced by our beneficiary communities is fairly homogenous. However it appears from data from our Title II programs, that **male children** are more likely to be malnourished than females. One explanation for this disparity is that males in our Phase I districts were found to be almost two times more likely to have had diarrhea in the past two weeks as females (baseline KPC, OR = 0.52, CI: 0.28-0.96, p = 0.02). Children born to younger women (< 28 years of age, the median age for the KPC) were also almost four times more likely to have a child with severe malnutrition (OR = 3.56, CI: 1.58-8.11, p=0.0005).

g. Linkages and Complementary Activities:

FH's decision to conduct the expanded impact program in Sofala was based on its successful work there, the partnerships that have been formed with other agencies and NGOs, and the high levels of poverty and health needs. FH has worked in four districts of Sofala province for the past 14 years, managing over $34M in project money since its inception, and maintains a well-organized and equipped base of operations in Beira, the capital city of Sofala province.

FH's project design for this expanded impact child survival project is based on the highly successful Care Group model used in FH/Mozambique's Title II health program. For the past six years, FH/Mozambique's Title II health program has shown excellent performance, far outpacing the four other Title II PVOs in Mozambique (and most nutrition projects in the world) in terms of nutritional impact and speed of change in results-level indicators. During the period 1998 to 2001, **FH/Mozambique decreased malnutrition** (HAZ<-2) **by 40%** (from 50.4% to 30.3%, p<0.05) **with concomitant, dramatic changes in mothers' nutritional and other health practices.**[15] (Please see the table below.) This program has continued to receive funding under Title II for four districts, and additional interventions have been added (HIV/AIDS and malaria) since its conception.

---

[14] http://www.unicef.org/mozambique/child_survival.html

[15] Berhane, Y and Tesfaye F. (Sept. 2001). Food for the Hungry International / Mozambique Health/Nutrition Program Final Evaluation Report.

Selected Title II Health Project Indicators	Baseline (1998)	Final (2001)	Percentage Change
Percentage of children malnourished (**height-for-age Z-score < -2.0)**	50.4%	30.3%	- 40%
Percentage of participating children <= 4 months **exclusively breastfed**	46%	61%	+ 33%
Percentage of participating children 6-10 months receiving **at least three meals a day**	24%	57.6%	+ 140%
Percentage of participating children 6-10 months with **oil added to their weaning food**	29%	72.8%	+ 151%
Percentage of participating children 6-23 months consuming at least one **vitamin A food** the previous day	59%	93.6%	+ 59%
Percentage of children 12-23 months who **received vitamin A** in the past six months	1%	82.6%	+ 8160%
Percentage of children 12-23 months in target area with **DPT3**	49%	73.9%	+ 51%
Percentage of participating children with diarrhea receiving **increased liquids**	49%	55.8%	+ 14%
Children consuming the **same amount or more food** during diarrhea	22%	48.5%	+ 120%

The percentage of children 2-23m of age who were *severely* stunted was almost cut in half during this project, from 25% at baseline to 13% at final ($p<0.05$, n=2,337). (Wasting in children 6-23m of age was not measured at baseline, but was found to be 9%, below the provincial average, at final.)[16] **Preliminary results from a mortality study conducted with the support of JHU (2004) found that the U5MR dropped by 62% (107/1000 to 41/1000), from 1999 and 2003 in areas where FH has used Care Groups. The IMR decreased from 66 to 38 (42%).[17]**

Given these dramatic changes and encouragement from the provincial MOHs to expand the program, FH decided to seize the opportunity to partner with the provincial MOH, HAI, CUAMM, and other agencies to take the Care Group model to scale in Sofala Province, one of the poorest provinces in Mozambique

In addition to its Title II activities, FH is currently addressing HIV/AIDS through a **$8.2M PEPFAR (ABY) grant,**[18] with $2.2M of that being used in Sofala province for prevention of HIV, largely among youth. FH/Mozambique also will receive $480,000 over the next three years for home-based care, care for orphans and vulnerable children, and prevention of HIV as part of FH's **Bringing Hope project** in Mozambique (Sofala), Uganda, Rwanda, Kenya, and Ethiopia. This project currently operates in four of the Sofala districts (with plans for expansion in an additional three) included in this CS program. Funds were made available for this program from a $2.5M grant from a Christian couple in the U.S which will complement the $8.2M PEPFAR grant, thereby bringing its total value to $10.7M. Examples of linkages with this project include having the youth in the ABY Project promote a small set of key nutrition messages in the

[16] ibid.

[17] Anbarasi Edward, World Relief. Personal communication regarding pending report on joint FH/World Relief Mortality Study in Gaza and Sofala Provinces, Mozambique (funded by CORE). (November 2004).

[18] FH has received verbal approval for this grant from USAID, and has been told to expect a signed agreement by 24/11/04.

households with which they have contact, referral to LMs for advice on PMTCT and where people can obtain VCT, and sharing key nutrition messages with adults seen as part of the promotion of faithfulness activities of the ABY program.

The Catholic Church, Health Alliance International (HAI), CUAMM and AISPO also work in Sofala province.

ESMABAMA is a Catholic health project that was operational in three Sofala districts during the proposal phase of this program, two of which overlapped with our project districts – Machanga and Buzi. ESMABAMA began in 1992 with four health centers and now has a hospital. They were eager to partner with FH and address child survival, however, ESMABAMA's program funding has ended and they are no longer in a position to partner with FH in the implementation of this expanded impact program.

Health Alliance International (HAI) is currently implementing a CS project (that will be completed in 2007) in four districts of Sofala (Dondo, Nhamatanda, Gorongosa, & Beira). HAI's project in Sofala addresses STI/HIV/AIDS (40%), malaria control (35%) and maternal care (25%). This project works completely within the existing health facilities, therefore there is no overlap of interventions with FH's expanded impact program. HAI is also actively involved in various HIV/AIDs interventions and provides HIV testing and treatment. **FH will be partnering with HAI** in the implementation of this expanded impact program

The Italian NGO **Doctors with Africa (CUAMM)** currently implements projects in hospitals and other health facilities. As part of their activities at the central hospital in Beira, CUAMM operates a feeding center for severely malnourished children. CUAMM will also begin community based therapeutic feeding using plumpy nut. **FH will partner with CUAMM** in the implementation of this expanded impact program.

The **Italian NGO AISPO** (Italian Organization for the Solidarity of People) is implementing a three year program supporting the district level MOH in Caia (30%) and Chemba (70%). This support consists of training, logistics, construction of health facilities and housing for health personnel. They have also recently submitted for funding to extend programming into the district of Maringue. AISPO is not currently involved in community level interventions and is very interested in partnering with FH in the implementation of the expanded impact program. FH currently has a verbal agreement to partner with AISPO (please see letter outlining this relationship in Annex 4). However, the partnership will depend on program funding as the current AISPO program ends in May of this year. In the meantime, FH will include AISPO personnel in trainings in hopes that they will secure funds to allow them to implement the Care Group model as part of their programs in Chemba, Caia and Maringue districts.

Please refer to Section 3 for more detail regarding the roles of all partners

2. Summary of Baseline and Other Assessments

a. Briefly describe the types and methodology of baseline assessments conducted or to be conducted by the project, both qualitative and quantitative.
A KPC survey using LQAS was conducted in five of the ten project districts at baseline along with a local determinants of malnutrition study (an expanded PD study), a retrospective mortality study, and focus group discussions with mothers of young children and community leaders. **The sampling technique and interview process for the KPC, and descriptions of other baseline assessments (and results), are described fully in the Baseline Assessments Report (in English) in Annex 3.** A KPC (using LQAS), retrospective mortality study and focus groups will be conducted in the Phase II communities in April 2008.

b. Discuss the potential constraints to achieving program objectives and project strategies for overcoming constraints
One of the major constraints to improving health status of women and children in Sofala province is the lack of a mechanism and infrastructure for doing large-scale community health promotion. Without affecting the number or training of health facility staff, FH has been able to significantly decrease malnutrition (by 40%) and improve coverage levels and health status of women and children in its current coverage area at low cost using the Care Group model.

The three major potential constraints that exist in terms of taking this model to scale in Sofala are:

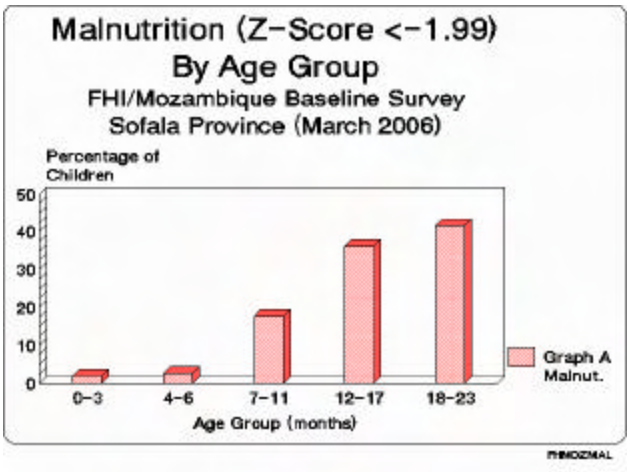
- **Lack of a public transportation system in many project districts**: We have increased the proportion of project budget going towards transportation so that we do not need to rely on a minimal – and in some cases non-existent – public transportation system. Still, mothers and Leader Mothers will need to walk longer distances in some communities in order to reach health facilities. The fact that 70% of mothers current have their children weighed (in the past 4 months) in health facilities gives us hope that we will be able to assure that a significant percentage will be able to reach health facilities for the services that we cannot or will not be providing as part of this expanded CS program (e.g., treatment for malaria). Also, given increasing gas prices worldwide, one threat to the program is if gas prices soar in Mozambique (along with other places in the world) over the next few years. *Were this to occur*, we would consider conducting Care Group meetings every month rather than every two weeks (as has been done successfully in other parts of the world [e.g., Cambodia]), and decrease supervision visits.
- **Lack of personnel, drugs and skills within MOH health facilities**: While improvements have been made in health facility capacity over the past few years (e.g., clinical IMCI training), numbers of MOH health staff are low, and supervision of health facility staff is still relatively weak. In order to facilitate the supervision of community-level health promotion staff (i.e., the Promoters and Leader Mothers), some of the supervision done of Care Groups will take place in the health facilities themselves. The President of the Care Group (a specially chosen Leader Mother) during special meetings at the health facilities – and the Leader Mothers themselves (when they go to the health facilities with their cohorts of mothers) – will be taught to report to the health personnel in the facility and to dialogue about problems that they

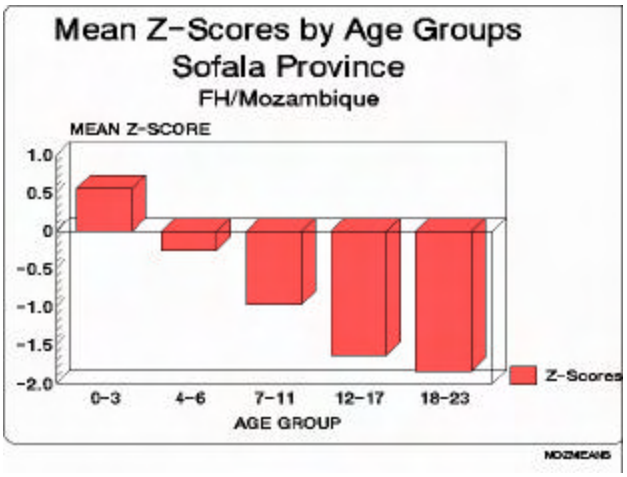
have found during their interactions with mothers. Also, given that our Title II Care Group project was enormously successful without targeting health facility functioning, we are confident that we can facilitate significant changes in health status in the same way: by concentrating on individual and household-level behavior change.

- **Centralized MOH planning**: There has been a recent trend towards centralized planning in the MOH. While this can help in terms of assuring the same standards and programs are applied across the country, it can make it difficult to get approval for innovations and ways of doing things that are found to be helpful in one province. Our CSP Manager will be making trips to Maputo several times per year, and will try to meet with national level MOH staff during these trips in order to foster a relationship with them that may help in terms of moving decisions through the system.
- **Unforeseen and untoward government policies**: A policy was created in Mozambique (with little input from PVOand NGOs) that required organizations doing home-based care for AIDS to pay their volunteers at a set rate. While we have not heard of any similar move being contemplated for child survival services, it is always possible that the government could require organizations to pay for volunteers who are currently not paid. Given that the Care Group model relies on thousands of volunteers, we do not have a good back-up plan for this unlikely possibility.

c. Give the most up-to-date coverage estimates in the service area relevant to each intervention.

26% (146 of 557) of the children 0-23m of age in the project districts are malnourished. The pattern of Z-scores shows a steady decline until 18m, then leveling out. The graph on page 3 shows that underweight generally levels off in Mozambique, in general, at about 11m. From FH/Mozambique's Title II anthropometry studies, it's clear that the peak in Sofala is closer to about 18m. This fits nicely with FH's plan to intervene intensively during pregnancy and the first two years of life since nutritional status deteriorates the most during those first two years of life.





Several cross-tabulations of anthropometry data (for index children) were calculated, and the following statistically-significant associations were found:

- **Younger mothers** (< 28 years, the median age of respondents) **were more than three times as likely to have a severely malnourished child than older mothers** (≥ 28 years, OR=3.56, CI: 1.58-8.11, p = 0.0005).
- Interestingly, **younger mothers were also more than 2.5 times more likely to feed their child three times per day (non-liquid feeds) than older mothers** (OR = 2.47, CI: 1.1-5.6, p = 0.02). These two associations will be explored in more depth prior to completing the educational modules on nutrition. It is not currently understood why these younger mothers are more likely to have a severely malnourished child.
- **Children with diarrhea were about twice as likely to be malnourished** (OR = 0.48, CI: 0.24-0.96, p = 0.02). 51% of malnourished children had diarrhea vs. 33% of those who were not malnourished.

43% of mothers breastfed their child within one hour of birth. 80% said that they gave their child colostrum ("the first liquid that came out of your breasts"). 12% gave prelacteal feeds. Of those, 7% said that they gave animal milk, 5% gave water, 5% gave tea, 3% gave a liquid or semi-liquid traditional medicine, 3% gave fruit juice, and 2% gave water with sugar or salt. 99% of children were ever breastfed, and 92% of the children of mothers interviewed were currently breastfeeding. Of those who had stopped breastfeeding, the average age of weaning was 13.4 months: 18% stopped at 6m or earlier, 36% stopped at 12 months or earlier, and 78% stopped at 18 months or earlier.

Only 17% (CI: 8.2-30.3%, 9 of 52) of children 0-5m of age were exclusively breastfed.

Dietary diversity is poor. Consumption of vitamin A foods is low with only 29% of children 6-23m of age having consumed at least one vitamin A rich food in the previous day, and no more than 35% of children 6-23m of age had oil added to their food. Vitamin A supplementation, however, is fairly good: 82% of mothers of children 12-23m of age either said that the child had received a vitamin A supplement in the past six months or had a vitamin A dose noted on the child's growth card. Adding oil to a child's food increases with age: 6% of 0-5m olds, 17% of 0-11m olds and 36% of 12-23m olds had oil added to their food.

Introduction of solid foods is good: 80% of children 6-9m of age had received both breastmilk and complementary foods the previous day. However, meal frequency is low: **only 33% of children 9-23m of age received foods other than liquids at least three times per day**. The average number of non-liquid meals given to children 0-5m, 0-1m, and 12-23m is 0.9, 1.3 and 2.2 times respectively. Children over five months of age should be eating five to six times daily, and some of these should be semi-solid or solid foods.

Bottle feeding is relatively rare: Only 12% of children 0-5m of age, 10% of children 0-11m of age and 4% of children 12-23m of age received food/liquid in a baby bottle the previous day.

Use of iodized salt is not very common (but saltwater fish are included in the diet occasionally). For children 0-5m, 76% of the mothers showed the interviewer salt that was not iodized, and in 24% of the cases, it was not possible to determine if the salt was iodized or not. For children 0-11m, 4% of the salt used was iodized, 79% was not iodized, and in 17% of the cases, it was impossible to determine.

In terms of growth monitoring, 88% of mothers had a card for the child available for the interviewer to see, and an additional 7% said that the card was not available or lost. Of those with cards, 78% had been weighed in the first month of life, and 70% had been weighed in the past four months.

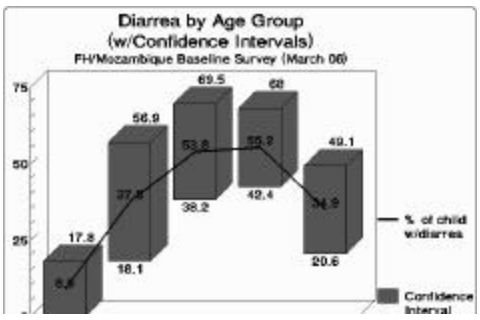
76% of the children over 11m of age had been dewormed in the last six months. Given the effect that worms can have on appetite, child growth, and illness, it should be a priority for this project to deworm all children over 24m of age.

Repeat infections and improper home management of infections is a common cause of malnutrition, and it is definitely a contributor to malnutrition in the project area (see sections below).

To summarize, **the most problematic nutritional behaviors and probable reasons for malnutrition in the project area are:**

- **Poor rate of exclusive breastfeeding;**
- **poor frequency of feeding;**
- **low early initiation of breastfeeding;**
- **low consumption of vitamin A foods;**
- **low consumption of protein-rich foods, especially legumes;**
- **poor dietary diversity;**
- **low nutrient density of foods given;**
- **high prevalence of diarrhea;**
- **Poor dietary management during childhood illnesses;**
- **Poor hygienic practices (especially lack of handwashing and disposal of excreta)**

The educational messages developed for this project should be based on these key problematic behaviors through the Care Group structure. While growth monitoring rates are not very bad, FH should encourage more mothers to take their children for regular GM/P and fortify this with increased nutritional counseling at the community level.



1. Diarrhea, Water and Sanitation

40% (95% CI: 33.3-47.4%) of children had diarrhea in the past two weeks as compared to only 12% of children 0-59m in all of Sofala in the 2003 DHS. This difference is probably due to the fact that the KPC was conducted during the high season for diarrhea. It may also be due to having particularly high diarrheal rates in our project districts. (The final KPC will be repeated at this same time of year.) Analysis by age groups shows that **diarrheal prevalence is particular high in the 7 – 17m age group where it surpasses 50%** (see graph). A cross-tabulation showed that **diarrhea is almost twice as prevalent in males** (OR = 0.52, CI: 0.28-0.96, p = 0.02). This may be behind the trend we that FH has seen in their Title II programs where preschool males were found to be more malnourished than preschool females. That trend was not found in this survey (which focused on a younger age group, 0-23m). Children with diarrhea were also twice as likely to be malnourished (as mentioned above).

Water and sanitation practices in the project districts were found to be quite poor. 45% of households get their water from springs, rivers, or streams, 21% from public wells, and 17% from lakes, ponds, or dams. **Only 41% of respondents purified the water that they gave to their child** (i.e., the index child) using an effective method. The last time they defecated, 77% of children defecated in a cloth or washable diaper and 7% defecated outside of the house on the ground (but not in a hole dug for that purpose). 41% of mothers of infants[19] claimed to have a special place to wash their hands, but 4% had everything required: **only 8% had water, 14% had soap/ash, and 38% had a basin**. When asked when they wash their hands, only 1% of mothers mentioned the four correct times.

71% of children 0-23m with diarrhea in the last two weeks received ORS and/or recommended home fluids (RHF). 90% of mothers had heard of ORS. Of the mothers of children who had diarrhea, and who could describe how to make ORS properly, 92% (CI: 79-92%) gave ORS or RHFs to their children. However, only 44% of mothers had heard of ORS and were able to describe how it is made (from packets) correctly. 44% of children with diarrhea were given ORS packets, 21% were given pills or syrup, 7% were given home or herbal remedies, and 13% gave nothing at all. **FH should work towards assuring that all mothers have ready access to ORS packets** (e.g., through the Leader Mothers) **and that all mothers know how to make ORS properly**. Our data shows that most all of the mothers who can explain how to make ORS properly will use it. FH should also work to increase availability of ORS packets and improve knowledge in each community through the Care Group structure. This should be a priority activity given that diarrhea remains a killer disease in Sofala province.

Hydration and rehydration during diarrhea is poor. When children had diarrhea,

- **38% (30 of 80) of mothers offered less fluids to the child**,
- **33% of mothers offered the same amount of fluids,**
- 25% offered more liquids, and

[19] Questions on hygiene were only asked of mothers of infants in order to keep the questionnaire a reasonable length.

- 5% offered the child nothing to drink at all.

Feeding during diarrhea is also poor with less than one-third of mothers giving the same or more food. When children had diarrhea:

- **56% (44 of 79) offered the child less to eat**,
- 19% offered the child the same amount to eat as usual,
- 12% offered the child more to eat, and
- **13% offered the child nothing to eat.**

Feeding following diarrhea is poor, as well, with only 12% offering the child more to eat. When children had diarrhea:

- **46% (86/189) were offered the child less to eat**;
- 20% were offered the child the same amount to eat as usual;
- 12% were offered the child more to eat; and
- 22% of children had never had diarrhea.[20]

We included questions on care seeking in the sick child section of the KPC questionnaire. Of the children who had diarrhea in the past two weeks, care seeking was mediocre: 51% sought care outside of their home. Of those who did, 41% sought care in a health center, 31% at a health post, 12% from a traditional healer, 7% from a hospital, and 9% from other sources. **In terms of danger signs during illness** (discussed further below), only 16% of mothers mentioned "vomits everything," 15% mentioned "lethargic or difficult to wake," and 28% mentioned "not eating or drinking."

In summary, diarrheal prevalence is quite high (particularly in the 7-17m age group), and the chief causes for that are apparent: using water from unsafe sources, poor purification of water, very low rates of handwashing (and not having the materials on hand necessary to do so), a very low rate of exclusive breastfeeding, and malnutrition. Recognition of danger signs often seen with diarrhea is poor and probably leads to a high level of preventable morbidity and mortality from diarrhea in these communities. **The most problematic behaviors related to diarrhea and probable reasons for weight loss and death during diarrhea in the project area are:**

- **the high prevalence of diarrhea itself;**
- **extremely poor hydration and feeding during (and after) diarrheal episodes;**
- **poor maternal knowledge in terms of how to prepare ORS from packets;**
- **very low levels of hand washing (and possibly other hygienic practices not explored)**

2. Sick Child / IMCI

[20] This question was asked of the mothers of all children (not just those with diarrhea).

In the two weeks prior to the survey, children of mothers interviewed had the following illnesses:

- Diarrhea: 40%
- Blood in stool: 4%
- Cough: 41%
- Difficult breathing: 10%
- Rapid/difficult breathing: 4%
- Fever: 55%
- Malaria: 21%
- Convulsions: 3%
- Other illness: 8%
- No illness: 16%

51% of mothers went for treatment when their child had one of the above illnesses. Of those who sought care, most went first to health centers (48%), health posts (28%), and traditional healers (10%). Fewer than 4% mentioned CHWs, community distributors, pharmacies, friends, or kinfolk (combined) as a first-line source of care.

The second place that mothers went for treatment were health centers (46%), health posts (26%), traditional healers (12%), and hospitals (6%). As second-line sources of care, 3% of mothers went to pharmacies, none went to friends or kinfolk, 2% went to CHWs, and 1% went to community distributors.

Hydration and rehydration during illnesses (in general) is poor. When children were ill:

- **56% (95/169) of mothers offered less fluids to the child**,
- 25% of mothers offered the same amount of fluids,
- 15% offered more liquids, and
- 2% offered the child nothing to drink at all.
- (2% of children were not yet drinking)

Feeding during illnesses was also poor with less than one-quarter of mothers giving the same or more food. When children had illnesses:

- **59% (101/171) offered the child less to eat**,
- 15% offered the child the same amount to eat as usual,
- 8% offered the child more to eat, and
- **8% offered the child nothing to eat.**

75% of mothers (149/199) could state at least two correct signs[21] of childhood illness that indicated the need for treatment, but only 52% could site three signs, but many of the most important danger signs during illness were mentioned very infrequently:

- (1% did not mention any signs)
- 58% mentioned "looks unwell or not playing normally,"

[21] Signs included as correct were based on international IMCI protocols.

- 28% mentioned "not eating or drinking,"
- 15% mentioned "lethargic or difficult to wake,"
- 81% mentioned "high fever,"
- 6% mentioned "fast or difficult breathing,"
- 16% mentioned "vomits everything," and
- 6% mentioned "convulsions."

All of these danger signs should be included in FH's educational messages. Given that 40% had diarrhea in the past two weeks, FH **should be especially sure that lethargic or difficult to wake, not eating or drinking, and vomits everything are mentioned as danger signs by mothers**. Also, mothers should be taught to recognize fast or difficult breathing as a danger sign.

In summary, fever, diarrhea, and cough are the main illnesses that children 0-23m have in these districts, according to their mothers. Care seeking is mediocre, but the places where care is sought are generally sources that have trained medical staff. Dietary management for illnesses in general is quite poor. Knowledge of dangers signs is good concerning high fever, but is quite limited in general, especially for some of the more important signs related to diarrhea and pneumonia. FH should focus on improving mothers knowledge of all danger signs and proper dietary management of illnesses as a way to lower mortality and improve nutritional status.

d. Provide the most recent disease surveillance data available (i.e. from local HMIS)
Very little data was found on disease surveillance in the project districts aside from malnutrition (those who were interned) and cholera. Data for malnutrition (children hospitalized) in 2005 shows:

- 912 cases in Beira;
- 45 cases in Buzi:
- 26 cases in Caia;
- 63 cases in Chemba:
- 71 cases in Chibabava:
- 518 cases in Dondo:
- 112 cases in Gorongosa:
- 38 cases in Nhamatanda:
- 59 cases in Maringue:
- 66 cases in Marromeu.

Since very few parents take their children to hospitals for malnutrition, and given the anthropometric data, we know that the actual number of children with malnutrition is much higher.

For cholera, the 2005 data shows:

- 1,099 cases in Beira;
- 29 cases in Buzi:
- 467 cases in Caia;
- 0 cases in Chemba:
- 10 cases in Chibabava:
- 533 cases in Dondo:

- 17 cases in Gorongosa:
- 118 cases in Nhamatanda:
- 0 cases in Maringue:
- 216 cases in Marromeu.

Of the 13 districts in Sofala, 100% of the cases of cholera in 2005 were located in the 10 districts covered by this child survival project. As with the malnutrition data, we are confident that many parents do not use health services when their children have diarrhea, and the actual number of cases is probably much higher than the above data indicates.

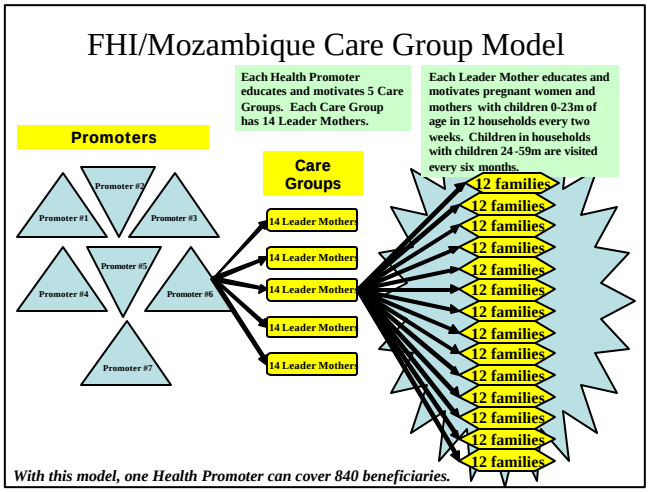
3. **Program Description –**

Goals and Objectives of this Program: This five-year **Expanded Impact** Child Survival Program (CSP) has three broad goals: (1) significantly reduce morbidity and mortality – especially among children 0-23m of age and pregnant women – in Sofala province; (2) Increase access to community/HH IMCI-trained health providers in the program areas; and (3) to transfer the knowledge, skills, tools, and passion needed for effective and sustainable community health development through the Care Group approach to project partners – including Leader Mothers – in order to continue child survival activities once this project has ended.

The four strategic objectives of the program are to (1) improve child nutritional status; (2) assure appropriate diarrhea case management (including proper feeding) and prevention of diarrhea; (3) increase the proportion of mothers of young children who have access to an IMCI-trained provider within one hour of their home; (4) assure the sustainability, quality and expansion of the Care Group Model in Mozambique.

This project will expand the Care Group network to new communities in ten districts - Beira, Buzi, Caia, Chemba, Chibabava, Dondo, Gorongosa, Nhamatanda, Maringue and Marromeu - in Sofala province building on current Title II and HIV/AIDS prevention and support programs.

Program Strategy:



This **expanded impact** program uses FH's Care Group methodology to foster behavior change at the household and community levels in order to achieve equity, coverage, and impact. It also strengthens the public health system in Mozambique through the participation of our MOH and NGO partners. In FH's methodology, an initial census is done to divide households with children under two years of age or pregnant women into groups of twelve. (Other households with children 2-5 years are also put in the charge of each Leader Mother (LM), but those households are visited less frequently – every six months.) Each twelve-household group elects a LM under the guidance of the Promoter. A group of 14 LMs forms a Care Group. Each Promoter serves five Care Groups, and meets with the LMs in each Care Group every two weeks for two hours.

During Care Group meetings, the Promoter teaches the LMs the health messages for the week using flipcharts and other educational materials and methods. LMs discuss the health lesson, report on illnesses of children in the households they serve, discuss problem cases (e.g., in terms of behavior change), and report on vital events. LMs practice their health promotion on the lesson that they just learned (in pairs), supervised and coached by the Promoter. Other social activities – such as songs, dramas and games

– are also incorporate to facilitate learning. Care Group Meetings generally last about two hours.

During the two weeks between meetings, each LM does health promotion, using smaller flipcharts, through home visits to each of the twelve households with women/mothers that she serves (i.e., ***all*** of the households with pregnant women or children under two). This pattern of work allows the Promoter to spend an entire day in the catchment area of each Care Group, spending the morning in the Care Group meeting where the week's lessons are taught, and the afternoon to work with several Leader Mothers. During their time with the Leader Mothers, the Promoter observes/supervises their work, helps them troubleshoot, and conducts verbal autopsies (see **Section 5** for more information regarding supervision).

FH believes that this model works because of the impressive results seen in FH's Title II health project (which did not involve food distribution, only health promotion through Care Groups), including a **statistically significant 40% drop in malnutrition**. (See **section 1.g** for more details.) Project staff has noted that CG members often meet on their own (without project personnel present) simply because they enjoy spending time with each other. During those meetings, they help each other learn, plan, and socialize. Many women in this poverty-stricken part of Mozambique often report that they have not had previous opportunities to meet in groups. CGs give them that opportunity.

FH's strategy is to partner with the **Sofala provincial MOH, CUAMM, PWCSA**, **HAI, AISPO,** and other partners to implement FH's highly successful Care Group model for improvements in nutrition, diarrhea, and household and community IMCI throughout Sofala province. Given the lack of community-level health promotion and poor nutrition and diarrhea indicators in Sofala, 69 Promoters and 4,830 Leader Mothers working through 345 Care Groups will be trained and put into place in ten districts in Sofala province. All 69 Promoters and one Leader Mother per Care Group (345) will receive training in community and household IMCI, and learn to assess, classify, refer, and provide advice on home management to mothers in the communities where they work. Each of the 4,830 Leader Mothers will provide quality health promotion on a biweekly basis in twelve households with a pregnant woman or children under two years of age (the most vulnerable age group). Training and supervision of Promoters will be done jointly by FH and its partners in Sofala so that the partners can continue maintaining the structure once the project has ended.

Quality Improvement will be carried out in this project through three principal methods: **creation of high-quality curricula, use of QI tools, and regular review of quality data for decision making** in meetings of project staff and partners. High quality curricula will be one means to assure that project staff from the CSP Manager down the the Leader Mothers are all speaking the same language and have clearly in mind the behaviors that we are trying to change as a result of this project. The main QI tools which we will use are **Quality Improvement and Verification (QIV) Checklists**. Project staff will identify the key processes that are repeated often in the project (e.g., educational sessions, vitamin A supplementation, data collection procedures), and will use or create QIV

checklists to measure the quality of these processes on a regular basis, and to encourage the worker conducting each process. The focus of the feedback using these checklists is on encouraging the worker so that their self-confidence in their ability to do the process is built up, so they develop an interest in doing things well, and so they learn to appreciate (rather than fear) being supervised. (FH has had success in using these checklists, and will be presenting on the use of the checklists in the upcoming CORE Spring Meeting.) The checklists will be used by the CSP Manager with the HPSOs, by the HPSOs with the Promoters, and by the Promoters (using a simplified version) with the Leader Mothers. **Pre- and Posttests** will also be used in each project training to assure that the quality of trainings is high, and to give supervisors a means to assess individual learning. Individual feedback and remedial training can then be given during supervision visits. Verbal posttest will also be used in the Care Groups with Leader Mothers. Quality data will be reviewed in meetings and by supervisors and trended along with other project data.

Sustainability will rely heavily on the continuation of the Care Groups themselves, and studies in Mozambique have shown that Care Groups continue to meet and do health promotion long after project funding has ended. Studies conducted by World Relief in Gaza province found that of the 1,457 volunteers active at the end of a Care Group project, 1,361 (93%) were active twenty months later. Of the original number, 92 LMs had left their post or moved out of the area and 44 had died. Out of these 132 vacant roles, the communities had selected 40 replacements, and other volunteers trained their new colleagues and entrusted them with the educational materials of their predecessors. Furthermore, the changes brought about in the original program – similar to FH's dramatic changes with its Title II Care Group project – were maintained during this period, as well. A full thirty months after the end of the project, final program goals on eight key indicators continued to be exceeded. While FH has not yet pulled out of the communities in Sofala where Care Groups have been established (using Title II funds), FH has have seen the same low turnover rate and exceptional impact and changes in results-level indicators that are associated with a successful, community-supported project.

The health promotion messages developed through this project will not only reach households through the Care Group structure, but **using PEPFAR and private funding, will reach an additional 345,000 youth and their families through 1,760 church-based, school-based and community-based Youth-to-Youth Groups that FH will establish in four of the Sofala districts included in this plan –**Marromeu, Caia, Nhamatanda and Gorongosa. FH will also be addressing PMTCT, care of OVCs and HBC through its separately-funded HIV/AIDS programs in Sofala.

In the districts (Nhamatanda, Gorongosa, Caia and Marromeu) currently served by **FH's Title II health program**, resources will be combined to extend the network of Care Groups to the entire district (or most of the district, in the case of Marromeu). HH/C IMCI will also be added to the lesson plans covered by the LMs in those areas. Training of partners will generally take place at the district-level.

Several partners will participate in putting this system of Care Groups into place as well as giving the Promoters and Care Groups ongoing supervision and support. A **CS**

Coordination Team, will also help guide the implementation of program activities and will be comprised of representatives from FH, MOH, PWCSA, CUAMM AND HAI. The roles of each of our partners are as follows:

The **Mozambican MOH** will be responsible for helping to establish the Care Groups in the catchment areas of their health facilities in each district. The public-health MOH staff – usually public health nurses – who are part of the district-level MOH staff will accompany FH during this process, joining FH's paid Promoters in the training and support of each Care Group every three months (sometimes at the community-level and sometimes through meetings in their health facilities). This will *not* be often enough to introduce our interventions, and for that reason FH's Promoters will visit the Care Groups on a more frequent basis – every two weeks. However, it *will* be sufficient to provide ongoing support and supervision of the Care Groups once the program is in place (after two years). By participating every three months in the work with Care Groups, the MOH staff will learn what role they will need to take in the project over the long term. Both MOH and private partners' capacity will be built through participation in project trainings on the Care Group model, health promotion, HIS (e.g., verbal autopsies) and quality improvement, as well as joint supervision visits.

The MOH is also responsible for providing Community IMCI training to all FH Health Program Support Officials (HPSOs), previously called supervisors, and Promoters. They will also supply Promoters and Leader Mothers with ORS, Vitamin A, Iron and Mebendazole for distribution during semi-annual Hearth screenings and bi-weekly home visits. The Swiss NGO **Sight and Life** will provide the project with Vitamin A capsules when the MOH supplies are not adequate.

Provincial and district level MOH representatives will participate in all program trainings including Care Group modules, Hearth rehabilitation, supervision, CQI, and mini-KPC and data analysis. The MOH is also very enthusiastic regarding the receipt of community level data from this program that will further strengthen their current M&E system. For more information regarding M&E, please see section 4.

Health Alliance International (HAI) is very interested in our Care Group model as they are working to increase their level of community based interventions. HAI is actively involved in HIV/AID intervention and currently provides HIV testing in all of our program districts and will have treatment facilities operational in eight of our 10 intervention districts (but not in Chemba and Maringue). HAI will soon begin implementing a system of peer counselors/activist in health centers as part of their PMTCT activities. These peer counselors/activist are HIV+ mothers who will educate other mothers, during antenatal visits, of the importance of HIV testing. FH will provide Care Group module training to HAI peer counselors/activists so they can incorporate nutritional messages during their counseling sessions. HAI will participate in the development of CG lessons focused on HIV/AIDS – specifically related to PMTCT and available testing and treatment services provided by HAI in Sofala. HAI will also participate in the training of Promoters on the HIV/AIDS lessons. HAI will serve as a member of the CS Coordination Team (see section 5 for more details). Lastly, HAI will

work with FH in identifying ways in with the CG model and other methods used in the CS program can be integrated into current (and future) HAI projects to achieve better coverage and results. FH and HAI have signed a MOU which is located in Annex 4.

The **Provincial Women's Committee for Social Action and Coordination** ***(Direcção Provincial da Mulher e Coordenação da Acção Social)*** (**PWCSA) -** FH has worked previously with this government supported agency in developing a databank for orphan children in Sofala. PWCSA is primarily involved in working with disadvantaged populations – orphans, disabled individuals, female heads of household and the elderly. They have established community level committees that are responsible for identifying vulnerable populations in need of services as well as disseminating various types of information. PWCSA's community level committees are assisting in community census activities by assuring that all households are included and that vulnerable groups are not left out. These committees are also facilitating the recruitment of Leader Mothers and the participation of beneficiary mothers in program activities. FH Promoters will provide health and nutrition education to PWCSA community committees. Representatives from PWSCA will also participate in all program trainings and identify ways in which the Care Group model can be integrated into their current programs. FH and PWCSA have a signed MOU which is located in Annex 4.

Doctors with Africa (CUAMM) has worked in Mozambique since 1978 and aims to improve the health of rural populations by implementing projects in hospitals and other health facilities. In 2002, CUAMM launched an ongoing project in support of the Beira central hospital. In 2003 a public health care project was begun in the Beira and Dondo districts; and since 2004 there has been a support project at the Faculty of Medicine at the Catholic University of Beira. As part of their activities at the central hospital in Beira, CUAMM operates a feeding center for severely malnourished children. CUAMM will also begin community based therapeutic feeding using plumpy nut. FH will partner with CUAMM in the implementation of this expanded impact program. FH will refer severely malnourish children in Manga to CUAMM's feeding center in Beira for treatment. CUAMM will also provide community based therapeutic care (using plumpy nut) in tandem with FH's Hearth programs. Lastly representatives from CUAMM will participate in all program trainings and identify ways in which the Care Group model can be integrated into their current (and future) programs. FH currently has a verbal agreement with CUAMM. We had planned to have a written agreement by the submission of this DIP, however CUAMM has asked to delay the signing of the MOU until mid-May when their new Nutrition Program Director arrives in Mozambique. A copy of the pending MOU is located in Annex 4.

Food for the Hungry is responsible for conducting an initial census, community mapping and retrospective mortality activities. Food for the Hungry will hire Promoters, select Leader Mothers and establish Care Groups, and will develop training curricula and materials focused on nutrition and control of diarrheal disease. FH's Promoters will be responsible for biweekly training of all 4,830 Leader Mothers (organized into 345 Care Groups) on each nutrition and diarrhea education CG module, carrying out semi-annual malnutrition screenings, running the Hearth nutritional rehabilitation workshops,

collecting data for the HIS, and conducting verbal autopsies on children under two years of age. They will also be responsible for educating community leaders, traditional healers, traditional birth attendants and drug vendors on nutrition and diarrhea. LMs will be responsible for training the 57,960 mothers of children 0-23m of age and pregnant women on all of the nutrition and diarrhea messages. HPSOs will conduct monthly supervisions of each Promoter, and Promoters will supervise each of their 70 Leader Mothers every three months.

INTERVENTIONS:

NUTRITION (70%)

Currently 44% of deaths in Mozambique are malnutrition related. FH's baseline assessment found that 26% of children 0-23 months in project districts were underweight (WAZ<-2.0), only 29% of children 6-23m had consumed at least one Vit A rich food in the previous day, and only 35% of children age 6-23 months of age had oil added to their weaning food. Of all the feeding behaviors, exclusive breastfeeding is the most predictive of infant survival and our baseline found that **only 17% of children 0-5 months of age in project districts were exclusively breastfed**. Moreover, the 2003 DHS found the average length of exclusive breastfeeding in Sofala to be 2.6 months. There is a precipitous decline in exclusive breastfeeding after the first month of life: only 37% of one-month-olds, compared with 77% of neonates were exclusively breastfed.[22] Introduction of water during this period is a major problem (with 2/3 of children 0-5m receiving water) but many children also receive solid or semi-solid foods. Given the low water coverage and quality in Mozambique, the use of water in addition to breast milk raises concerns about the increase risks of disease, especially diarrhea.

Frequency of feeding and nutrient density of complementary foods are also major problems in Sofala. Our baseline survey confirmed that only 33% of children 9-23m of age receive three or more feedings per day (apart from liquids). Wasting in Mozambique increases with the introduction of complementary liquids and foods; therefore suggesting that the dietary needs of Mozambican infants who are being weaned are not fully satisfied. Children in Sofala often only receive plain cornmeal gruel and positive deviance studies done in several districts of Sofala found that malnourished children are rarely given snacks and are not encouraged to eat when they are not hungry.

Nutritional interventions to benefit both mothers and children must begin in the prenatal period. The 1997 DHS study found that Sofala had the second highest percentage in the country of mothers who claimed that their child was "smaller than usual" or "very small" (26.9%) at birth, and 12% of non-lactating Mozambican women experience chronic energy deficiency (BMI<18.5).

To improve the nutritional status of pregnant women and children in Sofala, FH will dedicate 70% of effort to nutrition interventions.

---

[22] Center for International Health Information (CIHI). (1995). Mozambique: Country health profile 1995. *CIHI Country Health Profile Series*. Arlington:Center for International Health Information.

a. Behavior Change & Communication

BCC at the **individual and family levels** on the following nutrition messages will be the responsibility of the 4,830 Leader Mothers who have biweekly contact with all beneficiary household, and Promoters during their monthly contact with families during supervision.

- Breastfeeding of infants immediately after birth and utilization of colostrum.
- Exclusive, on-demand breastfeeding of infants until six months of life [per the Mozambican MOH's norms]. Children should not be bottle-fed
- From 6m, children should be provided with appropriate complementary feeding, including iron-, iodine-, and vitamin-A-rich foods; BF should continue to 24 months or more.
- Complementary foods given to young children should be diverse, nutritionally-dense, and thick enough to give a child the calories that the child needs. Oil should be added to young children's food to assure that it is energy-dense.
- Women should go for VCT and ANC visits and know their HIV status. Women who are HIV+ should exclusively breastfeed until the child is six months (no longer) or until such time as exclusive replacement feeding becomes acceptable, feasible, affordable, sustainable, and safe. [Replacement feeding is anticipated to meet the AFASS criteria in few if any cases in the project area].
- Promotion of safe water and hand washing as an essential nutrition action. (See diarrhea section.)
- Cooked foods should not be stored without refrigeration for more than two hours and should be thoroughly reheated.
- Children should be dewormed every six months.
- Pregnant women and young children should consume iodized salt and marine products on a regular basis.
- Children from 6m onward should receive vitamin A supplements every six months, and should receive special treatment with Vitamin A when they have measles, and other severe infections.
- Mothers should receive vitamin A supplements within six weeks of delivery, or 8 weeks if the mother is exclusively breastfeeding.
- Children 0-23m of age should be brought for growth monitoring on a monthly basis.
- Sick children should receive extra fluids, including more frequent breastfeeding, and be encouraged to eat soft, appetizing, favorite foods. Child should be given food more often during recovery.
- Children who are malnourished should be brought for a medical examination.
- When a child will not eat or is losing weight, or a mother has trouble breastfeeding, the C-IMCI trained LM or Promoter should be contacted as soon as possible.
- Pregnant women should increase their nutritional intake, and should take iron/folic acid supplements during pregnancy *and* lactation

FH will recognize beneficiary and Leader Mothers who complete a certain list of accomplishments with their child by the time they "graduate" from the program (at two

years of age). These mothers will be designated as **"star moms"** and will receive a certificate and potential other types of incentives. Women will be identified as star moms if:

* their child was exclusively breastfed to six months;
* their child received all vaccines;
* their child received all vitamin A doses;
* their child was dewormed;
* the mother purifies the child's water;
* the mother can explain preparation of ORS; and
* the mother can explain IMCI danger signs;

We will be testing a Star Mom card, to be place on the back of the Behavioral Box to keep track of mother's completing key child survival tasks (please see section 4.d for more information about the Behavioral Box and Star Mom cards)

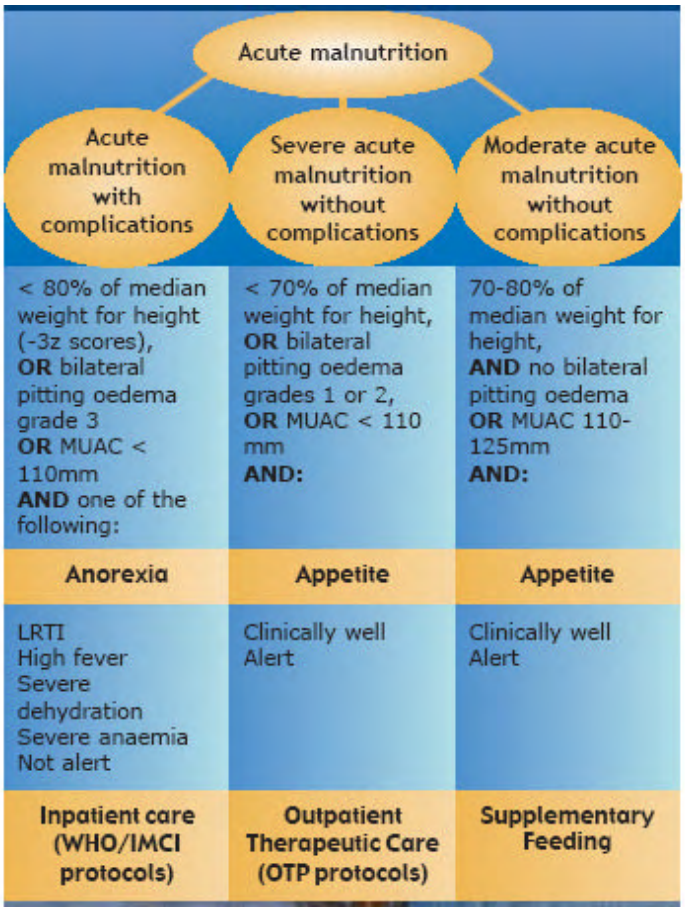
In addition to these behaviors and practices, FH will use the findings of **Barrier Analysis studies** to improve FH's nutrition education messages. Barrier Analysis is a method pioneered by FH which has now been disseminated to other PVOs with funding from CORE. It will be used to identify individual, household, and societal-level barriers to action for the most critical nutrition behaviors promoted (e.g., exclusive breastfeeding, feeding frequency). FH will use child's gender, birth order, and other variables in our KPC data set to do cross-tabulations with nutritional status in order to determine the correlates of normal and low WAZ in the project area to expand these messages. As part of the Hearth methodology, FH will conduct **positive deviance studies** to prioritize and expand our nutrition education messages. This data will be added to the findings from PD studies already conducted in key districts of Sofala where FH presently works in Title II. As part of an Institutional Capacity Building grant, FH HQ staff will continue to conduct detailed studies on localized determinants of malnutrition in Sofala province.

BCC at the **community level** (e.g., with community leaders, drug venders, and TBAs, in addition to the LMs) will be the responsibility of the 69 Promoters. An **additional 345,000 youth and their families** will be reached with key nutrition messages via 1,760 church-based, school-base, and community-based Y2Y Groups (see Section E.1.g above) using PEPFAR and other private HIV/AIDS funding. FH will explore collaborating with local radio stations for broadcasting nutrition and other health education messages during this project. (One quarter of women in Sofala listen to the radio every day.) BCC at the health worker level will be accomplished through the extensive trainings, which are part of this project, supervision, and CQI activities.

Children found to have moderate malnutrition (WAZ<-2), or who are severely underweight (WAZ<-3) *without* complications will be included in the **Hearth nutritional rehabilitation** program. While FH originally planned to refer all severely underweight children to the government Nutritional Rehab Centers (or pediatric wards of District Hospitals that serve as rehab centers where NRC do not exist), it was found from discussion with MOH representative that their system of rehabilitation is not working

well (due to methodology and the mother's poor access to NRC's). Also, they do not have the health staff necessary to treat severe malnutrition in the health posts. Consultation with FANTA has indicated that children with WAZ<-3 and no complications are candidates for Hearth.

However, FH will refer all children with acute malnutrition with complications (see chart below) or severe acute malnutrition (SAM), without complications, to a therapeutic feeding center.



[23]

Children with severe malnutrition in Manga will be referred to CUAMM's feeding center in Beira. Children living outside of Manga will be referred to the MOH nutrition rehabilitation program. Leader Mothers will conduct one-on-one counseling with the mothers of all malnourished children during regular home visits. We will work with our partners, including CUAMM, to see what improvements can be made to the government rehabilitation program.

The Hearth nutritional rehabilitation program will be done through the Care Group structure, twice a year (beginning in Year 3) in each community, following the pattern

[23] http://www.fantaproject.org/downloads/pdfs/ENNctc04.pdf

and methodology used in FH's successful Title II program. Mothers provide all of the food for these workshops, and the Promoter facilitates the workshop. FH's Hearth methodology is based on the Hearth manual produced by CORE. These Hearth sessions are done in the early morning so that they do not interfere with the Promoter's ongoing work with the other Care Groups. FH will train also train MOH staff and partner to use HEARTH.

Leader Mothers and Promoters will encourage mothers of children 0-23m of age to attend monthly MOH GM/P post conducted at health posts. Lead Mother will track GM/P attendance and weight loss or gain via the CG registries. Leader Mothers, to the greatest extent possible, will accompany their beneficiary mothers to GM/P and provide counseling to mothers after the MOH conducts child weighings. Leader Mothers will also be trained to read and interpret MOH Growth Cards so they can conduct additional counseling during their weekly home visits and will notify the IMCI-trained Promoter and LM in their group of any children who have nutritional problems (or other illness) so that they can be properly assessed.

Promoters and LMs will be trained to use open-ended questions concerning recent illness and dietary practices to identify possible problematic behaviors and causes for growth faltering for each individual child. Then they will ask closed-ended questions based on educational messages and their answers will be documented on a "behavior box" that they will maintain on a card they attach to the child's growth chart. The responses to these questions will serve as a "cue" to the Promoters and LMs to prescribe – or reinforce – the proper feeding pattern that the caregiver should follow during the upcoming month. Mothers will be generally counseled using the IMCI food box messages, but, using the responses to these questions, counseling will be tailored to each child's specific dietary and illness situation. Promoters and LMs will be trained to be sensitive to the barriers that mothers face in taking preventive actions, and will support mothers to work through these barriers. Selected MOH district staff members will also receive training in this enhanced GM/P

Every six months, FH will screen children (aged 0-59mths) for malnutrition and enrollment into Hearth. During bi-annual screenings, FH will provide deworming medication and vitamin A supplements. When possible, the district MOH staff will also attend these screenings to administer vaccines, as well.

b. Quality Assurance

The proposed program is thoroughly consistent with the MOH's policies concerning nutrition and micronutrients. It was designed in collaboration with both the provincial and national MOH nutrition office representatives. The nutrition messages FH will use agree with those used in Mozambique's IMCI food box. The MOH nutrition policies are consistent with most international norms.

The Mozambican MOH is implementing the WHO IMCI strategy for nutrition and micronutrients in the country. These nutritional protocols include assessment,

classification and treatment and counseling of caretakers of the children. Growth monitoring is promoted in the clinic and at the community level; however it is reported to be rarely done at the community level due to a lack of MOH health personnel and a focus on immunization and distribution of micronutrients during national immunization days. During the session with a child, health workers assess the nutritional condition of the child to determine if the child is malnourished or anemic. The protocols recommend asking, observing, and exploring if the child has signs of malnourishment or anemia. These signs include visible emaciation, edema in both feet, low weight for age as determined by the standard growth chart on the child health card, and pale palms. Based on the assessment a classification of the child's nutritional status is determined. The classifications may include severe malnutrition; moderate malnutrition; dietary problems; adequate weight with no dietary problems; severe anemia; anemia; and, no clinical evidence of anemia. The MOH policy now promotes exclusive breastfeeding until 6 months of age, and introduction of complimentary foods beginning at 6 months of age. Complimentary feeding is recommended until 2 years of age and MOH IMCI recommendations include appropriate foods, their amounts, and number of feeding sessions per day based on the child's age.

Using the pattern from FH's previous work with Care Groups, HPSOs will be responsible for biweekly supervision of approximately ten (paid) Promoters. On a quarterly basis, the MOH district staff will join the HPSOs in their supervision of the Promoters (both during the project period and afterwards). As the project proceeds, the District MOH staff will take a greater role in the supervision functions. The HPSOs will be accountable to the CSP Manager. Each Promoter is responsible for educating and supervising the work of the LMs in the five Care Groups that they serve.

The quality of nutrition education and micronutrient supplementation will be assured and improved through the establishment of policies and curricula that outline the proper procedure for each part of this nutrition intervention. Also, QIV checklists on IMCI and educational methods (as mentioned above, see Annex 12) will be used during the HPSO (and sometimes partners') biweekly supervision of the Promoters. Promoters will use QIV checklists on individual counseling and IMCI during their biweekly supervision of the Leader Mothers. These quality improvement checklists also will serve as a measure of the impact of the training in the nutritional interventions. The project staff will be trained in supervision and quality improvement techniques by the CSP Manager (including the use of quality improvement checklists) in June 2006. These QI checklists have helped FH's health workers in Mozambique and other countries to achieve very high levels of performance.

Promoters will ensure that community data are valid through periodic and random spot checks of the reported data. These spot checks will compare household level data with data in the report forms maintained by the Care Groups (i.e., the Care Group Report Form).

Information regarding availability of Vitamin A, Iron supplements and Mebendazole/ Albendazaole can be found in section 1.E. All health posts are equipped with child

weighing scales that are provided by UNICEF.

Access to Services

One of the major strengths of the Care Group model is that it provides health education via home visits, therefore addressing a primary barrier in the exiting MOH system - the lack of a mechanism to do large-scale health promotion due to the non-existence of CHWs. By having LMs visit *every* caregiver of children under two, equity for nutrition education is ensured. LMs will also notify the IMCI-trained Promoter and LM in their group of any children who have nutritional problems (or other illness) so that they can be properly assessed.

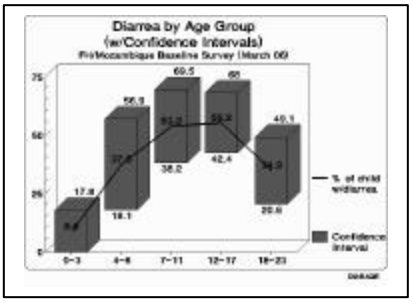
Controlling spouses and debilitating illnesses (e.g., AIDS) sometimes keep women from attending group activities, so a health promotion system based on biweekly home visitation from a female neighbor (the LM) has a greater ability to reach all mothers than one that requires all women to come to a central location. (This does not affect LMs since they are chosen, in part, for their ability to attend the meetings and to visit mothers in their charge.) FH's HBC program will also help HIV+ mothers to better care for their children and facilitate PTMCT. A recent review of the SAFAID program[24] found that the following led to decrease in MTCT and these messages will be incorporated into Care Group lesson plans.

- Good breast-feeding technique, particularly in attachment and positioning.
- Exclusive Breast-feeding for up to six months.
- Avoid now or re-infection, ie barrier contraception during pregnancy and lactation.
- Early treatment of breast and nipple problems (mastitis increases the risk of transmission.)
- Early treatment of oral problems in the babies.
- Consideration of rapid weaning in six months

PMTCT will also be addressed during lesson plans developed by HAI. Theses lessons will focus educate mothers on HIV/AIDS, preventing transmission, and providing information regarding testing and treatment options provided in Sofala province.

[24] http://www.kubatana.net/html/archive/hivaid/040623kub.asp?sector=HIVAID&range_start=211

CONTROL OF DIARRHEAL DISEASE (30%)



During baseline assessments, FH found that **40.2% of children 0-23m had diarrhea** during the previous two weeks. An IMCI study conducted in March 2003 found that 96% of health facilities had stocks of ORS yet in 82% of the cases in Sofala, home remedies were used for diarrhea. Our baseline survey found that 92.6% of mothers surveyed knew about ORS but only 44% of mothers could correctly prepare ORS. Only 31% of children aged 0-23 months with diarrhea in the 2 weeks preceding the survey were offer the same amount or more food during the illness. Furthermore hand washing and water purification need to be dramatically improved to deal with the very high diarrheal rates. Baseline data indicated that only 1% of mothers surveyed were practicing proper hand washing techniques and only 41% of mothers treated their child's drinking water using an effective method. Cholera outbreaks are common in Sofala, and a cholera emergency was declared by the MOH in January 2004.

In our program districts, diarrhea follows a similar age pattern to wasting with an upward trend throughout infancy, peaking between 12 and 17 months of age. The high prevalence of diarrheal disease among Mozambican children, coupled with the poor management of diarrheal disease within the health system, has been linked to widespread malnutrition.[25][26] Our baseline found that children with diarrhea were twice as likely to be malnourished (OR = 0.48, CI: 0.24-0.96, p = 0.02). For reasons unknown, our baseline indicated that males were about twice as likely to have had diarrhea in the past month as females (OR = 0.52, p = 0.02).

a. Behavior Change Communication

BCC at the **individual and family levels** on the message related diarrhea, including hygiene behaviors, will be the responsibility of the 4,830 Leader Mothers who have biweekly contact with all beneficiary households, and Promoters during their monthly contact with families during supervision. This will include preparation of ORS from packets, home dietary management of diarrhea, hygiene and sanitation, and the other topics listed below.

- Give children with diarrhea ORS, or RHFs. (Mothers will be taught to make ORS.)
- Continue to feed and offer more fluids (including breastmilk) to children when they have diarrhea, and increase feeding immediately after illness.
- Use locally-available Certeza (or bleach, if Certeza is not available, to chlorinate) to purify drinking water and safely store all drinking water used by the family to prevent cholera and other diarrheal diseases.

---

[25] Cliff, J., and Noormahomed, A.R.. (1993). The impact of war on children's health in Mozambique. Social Science and Medicine. 36(7): 843-848.

[26] Ministry of Health and Eduardo Mondlane University Faculty of Medicine. (1988). Evaluating the management of diarrhea in health centers in Mozambique. Journal of Tropical Medicine and Hygiene. 91:61-66.

- Wash hands with soap after defecation, before preparing meals, and before feeding children; and dispose of feces, including children's feces, safely. Use a *tippy-tap* or other water spreader to economize on water needed for hand washing.
- Properly dispose of feces through construction and use of latrines to prevent diarrhea.
- When a child has diarrhea, the G-IMCI trained LM or Promoter should be contacted immediately.
- When a child has signs of dehydration or general danger signs -- looks unwell, not playing, not eating or drinking, lethargic or change in consciousness, vomiting everything, high fever, fast or difficult breathing – the child should be taken to a trained health worker immediately.
- Cooked foods should not be stored without refrigeration for more than 8 hours. Avoid bottle feeding.
- Caregivers should follow health worker's advice about treatment, follow-up and referral for diarrhea.
- When a child has bloody or persistent diarrhea, seek care immediately from trained health workers. (Dysentery is fairly rare in Sofala, but persistent diarrhea – along with the HIV rate – is on the rise.)

In addition to these behaviors and practices, FH will use the findings of the **Barrier Analysis studies** (mentioned earlier) to improve our diarrhea messages and identify individual, household, and societal-level barriers to action for the most critical diarrhea behaviors promoted (e.g., use of ORS, hand washing). FH has also be in discussion with the MOH regarding **zinc supplementation** for children with diarrhea in project districts. The MOH has not yet approved the use of Zinc in Mozambique, however it is anticipated that such a protocol will be put in place in the near future. Once the necessary approval is secured from the MOH, FH will investigate the feasibility (contingent on funding) of providing Zinc supplements to children 0-59 months with diarrhea.

BCC on diarrhea at the **community level** (e.g., with community leaders and drug venders) will be the responsibility of the 69 Promoters. This will include BCC on the messages listed above, with an emphasis on how to chlorinate water (as part of efforts to control cholera). **An additional 345,000 youth and their families will be reached with key diarrhea messages** via 1,760 church-based, school-base, and community-based Y2Y Groups (see Section E.1.g above) using PEPFAR and other private HIV/AIDS funding. We will explore collaborating with local radio stations for broadcasting diarrhea prevention/management educational messages. BCC at the **health worker level** will be accomplished through the extensive trainings which are part of this project supervision, and CQI activities.

Promoters will have direct contact with mothers of children 0-23m every month through supervision, and contact with mothers of children 24-59m of age every six months during screening for HEARTH. (Deworming will be done routinely for children 12-59m of age during these screenings.) LMs will also notify the IMCI-trained Promoter or LM in their group of any children who have diarrhea (or other illness) so that they can be properly assessed. LMs serve a very small area (12 households), so it will be easier for LMs to stay abreast of the health situation of the children in their charge. Mothers of children

who have dehydration will be taught to give ORS or more fluids to the child during their trip to the nearest health facility. During cholera outbreaks, community leaders are assigned to each water gathering point. These leaders are given a chlorine solution by the MOH, and are responsible for putting chlorine in each container of water taken away from the site. LMs will be taught how to participate in these cholera prevention and mitigation activities as part of this project.

FH will also be partnering with PSI and Care for Life in Mozambique to promote the use of Certeza to purify drinking water. PSI will also conduct trainings on the use of Certeza and will provide program promoters and LM's with Certeza.

Leader Mothers will encourage all mothers of children 0-23m of age to seek out the community IMCI trained Promoter or Leader Mother in their Care Group when their child has diarrhea, and to go straight to a health facility when a child is dehydrated. Children identified with diarrhea by the LMs during the biweekly home visits will be referred to the LM or Promoter trained in community IMCI protocols for assessment, classification, treatment, and counselling. Children will be referred to the nearest health facility when appropriate.

INTEGRATION OF INTERVENTIONS (IMCI): FH and its project partners will focus on the 3 elements of HH/C IMCI:

Element 1: *Improving partnerships between health facilities and the communities they serve*. The staff of district MOH facilities and FH will have regular interaction with the Care Groups established in each area, which will greatly boost partners' direct involvement with communities. This will provide them with an efficient means of communicating with all families with young children or a pregnant woman. These health workers will also have access to the Care Group report form (HIS) maintained by each Care Group so that statistics on each neighborhood can be used for health programming (e.g., follow-up of defaulters).

Element 2: *Increasing appropriate and accessible care and information from community-based providers.* One LM per Care Group (345) and all 69 Promoters will be trained in the IMCI protocols for managing sick children 2-59m of age. (Protocols for children 0-2m have not yet been developed.) In addition to working with mothers of young children, both Promoters and LMs will regularly meet with community leaders, traditional healers and commercial drug venders to assure that they are educated on important health messages. This information will be augmented by outreach posts where children 0-59mth will receive screening for HEARTH, vitamin A, and deworming medication. District MOH staff will coordinate directly with each CG to carry out immunizations during these outreach posts when possible.

Element 3: *Integrated promotion of key family practices critical for child health and nutrition.* This project will make life-saving health information available at the household level through a network of 345 Care Groups with biweekly outreach to each household by 4,830 Leader Mothers.

Quality Assurance

Our intervention plan is thoroughly consistent with the MOH's policies concerning diarrhea (and HH/C IMCI), and was designed in collaboration with both the provincial and national MOH IMCI office representatives.

Using the pattern from FH's previous work with Care Groups, HPSOs will be responsible for biweekly supervision of approximately ten (paid) Promoters per district. On a quarterly basis, the MOH district staff will joint the HPSOs in their supervision of the Promoters (both during the project period and afterwards). As the project proceeds, the District MOH staff will take a greater role in the supervision functions. The HPSOs will be accountable to the CSP Manager. Each Promoter, in turn, is responsible for educating and supervising the work of the LMs in the five Care Groups that they serve.

The quality of this intervention will be assured and improved through the establishment of policies and curricula that outline the proper procedure for each part the intervention, and use of QIV checklists and pre/posttests (as described earlier). Bi-weekly supervision of Promoters will be conducted by FH Health Program Support Officials (HSPO) during which time they will use QIV checklists on IMCI and educational methods. These same forms will be used by Promoters during their biweekly supervision of the LMs.

As mentioned above, selected LMs (one per group) and Promoters will receive HH/C-IMCI training which will improve their counseling skills, as well. Promoters will assure that the IMCI-trained LMs are properly using the skills they have learned in IMCI by observing their management of sick children, and using an IMCI checklist to document and improve each trained Leader Mother's performance.

Information regarding drug availability can be found in section 1.E.

b. Access to Services

Each Promoter and the President of each Care Group (a LM) will maintain a stock of 50 ORS packets from the stocks kept at each MOH health facility. (Promoters live in the areas that they serve.) The President will make this stock available to the mothers represented in each Care Group, which will dramatically improve the accessibility of packets in the project area. ORS packets will be replenished during the biweekly Care Group meetings and Leader Mothers will keep on average a stock of 10 ORS packets.

Training in community IMCI for the 5 HPSOs, all 69 Promoters, and one LM per Care Group (345) will improve equity by giving mothers locally-available resource persons when their child is sick with diarrhea or other illnesses. Being based on based on biweekly home visitation from a female neighbor (the LM), this system has a greater ability to reach all mothers than one that requires all women to come to a central location. Also, by having LMs visiting *every* caregiver of children 0-23m of age through the Care Group strategy, equity for diarrhea education will be ensured. Use of the Star Mom cards (see section 4.d monitoring tools for more information) for follow-up on defaulters (e.g., for deworming) will help ensure equitable access to care, as well.

Scale up to Sofala Province Level (Phase In):
Given the large scope of this project, the work will be extended to the ten districts in two phases. **During the first phase** (first two and a half years), coverage in the first five Sofala districts - Caia, Chemba, Manga, Maringue, and Marromeu - will be extended, and seven health promotion modules will be used over 24 months in the first set of 150 Care Groups established there. During this period, extensive formative research (e.g., use of Barrier Analysis) will be done. Community IMCI training of Leader Mothers and Promoters in Phase I districts will begin in Year One of the project, training about 30 people at a time in each of these districts. In Year Three, Care Groups in the first set of five districts will continue to meet biweekly, but the Promoter will begin attending less frequently (on a monthly basis), in order to concentrate more effort on the Hearth Nutritional Rehabilitation program. Rather than going through each of the seven educational modules with each all mothers in a lock-step fashion, LMs in the first five (phase I) districts will begin choosing health promotion topics *based on the age of each mother's child* following a schedule proposed by FH and its partners. The most important health messages will be included during these biweekly health promotion sessions, but room will be left in the schedule, though, for *new* topics – especially malaria, maternal care, and HIV/AIDS – which will be introduced by FH's main partner organizations (the MOH, HAI, CUAMM and PWCSA). Other NGO and PVO partners will be invited to workshops and encouraged to use Care Group model in their districts, as well. **During the second phase,** 195 Care Groups will be established in an additional five districts in Sofala – Buzi, Dondo, Chibabava, Nhamatanda, and Gorongosa. They will follow the same pattern of work established in the first set of districts, moving through each of the seven CG educational modules, and following that will concentrate on an additional module with partners (e.g., malaria, maternal care, and HIV).

Training: (Please see the training table in section 7 for more details regarding training timing, length and participants.)

The trainings include an orientation workshop on working with Care Groups, HIS system, and other topics; a workshop on the Care Group/LM role, how to work with communities, BCC skills, vital events reporting, and maintenance of the CG Report Form; seven other Care Group educational modules that will be taught to each Promoter then to each mother of a child 0-23m and pregnant women. These seven modules are as follows:

- Module 1: Care Group Orientation – includes training in BCC
- Module 2: Sanitation and Hygiene
- Module 3: Diarrhea
- Module 4: Breastfeeding
- Module 5: Introduction of Complementary Foods
- Module 6: Micronutrients
- Module 7: Nutrition and Care for Pregnant Women

There will also be Supervision/CQI training; a data analysis workshop; mini-KPC & anthropometry workshop; use/analysis of verbal autopsies; and a final Lessons Learned workshop. The MOH as well as HAI, CUAMM, AISPO, PWCSA and other NGO representatives will be invited to these so that they can implement Care Groups in their projects, as well.

As mentioned above, selected LMs (one per Care Group) and all Promoters will receive IMCI clinical training, which will improve their diarrhea management and counseling skills. Management of bloody diarrhea will be covered during IMCI training. Promoters will assure that the IMCI-trained LMs are properly using the skills they have learned in IMCI by observing management of sick children, and using an IMCI checklist to document and improve each trained LM's performance. The HPSOs will do the same when they help supervise Promoters.

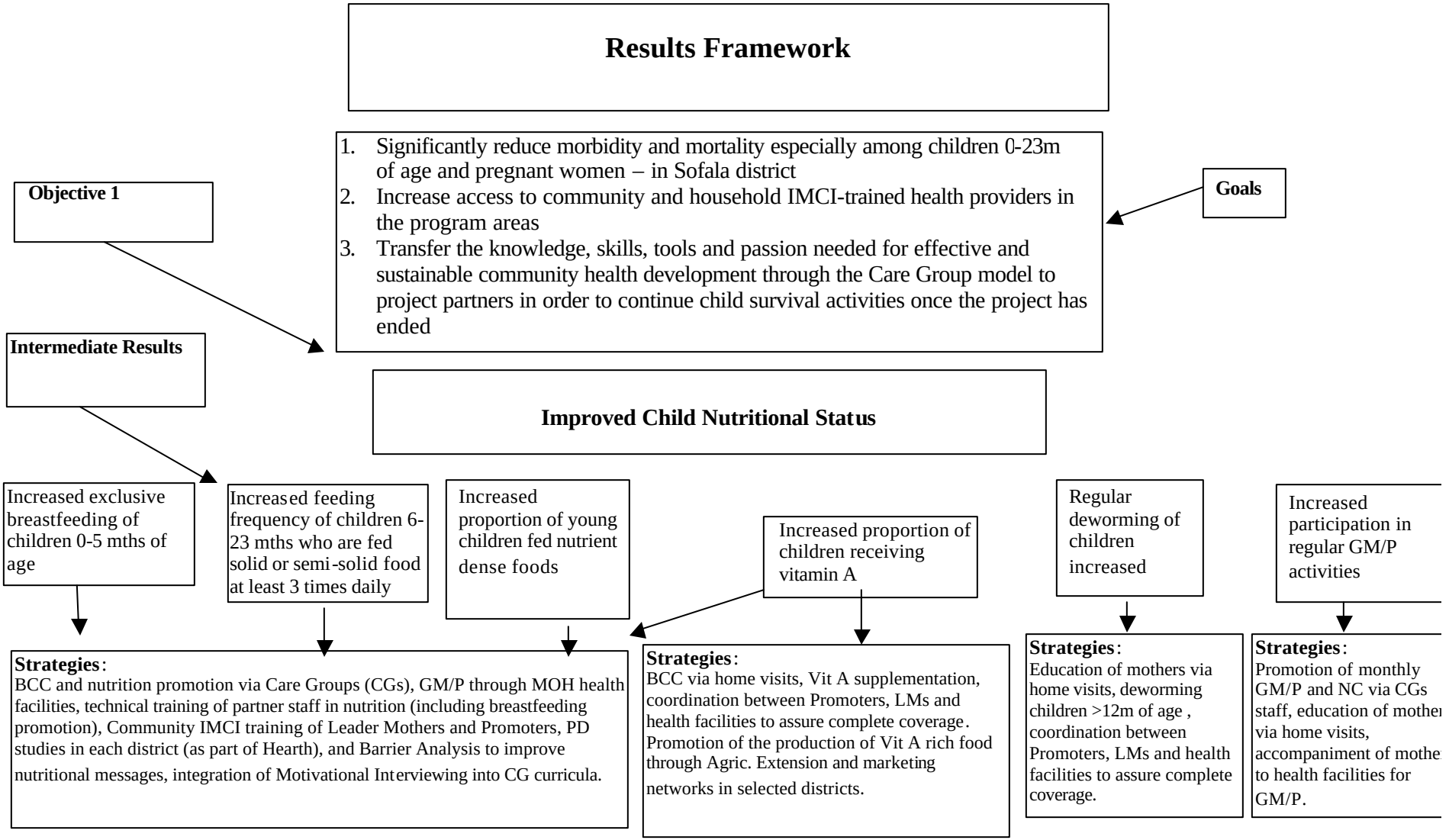
Contribution to CSHGP and USAID Mission program results:
Dr. Titus Angi, Health, Population and Nutrition Specialist with the USAID mission in Mozambique was consulted during the preparation of this DIP. This CS program is consistent with USAID/Mozambique's SO8 of the Country Strategic Plan for 2004-2010: "Increased use of child survival and reproductive health services in target areas". The Intermediate Results for this objective are (1) increased access to quality child survival and reproductive health services in target areas, (2) increased demand at community level for child survival and reproductive health services, and (3) more accountable policy and management. USAID Mozambique's goal is "broad-based rapid economic growth sustained through expanded capacities and opportunities." This child survival program will help USAID to meet these strategic objectives by greatly increasing access to quality CS services, and demand at the community level for CS services, by extending community and household IMCI and the Care Group structure to ten districts of Sofala provinces.

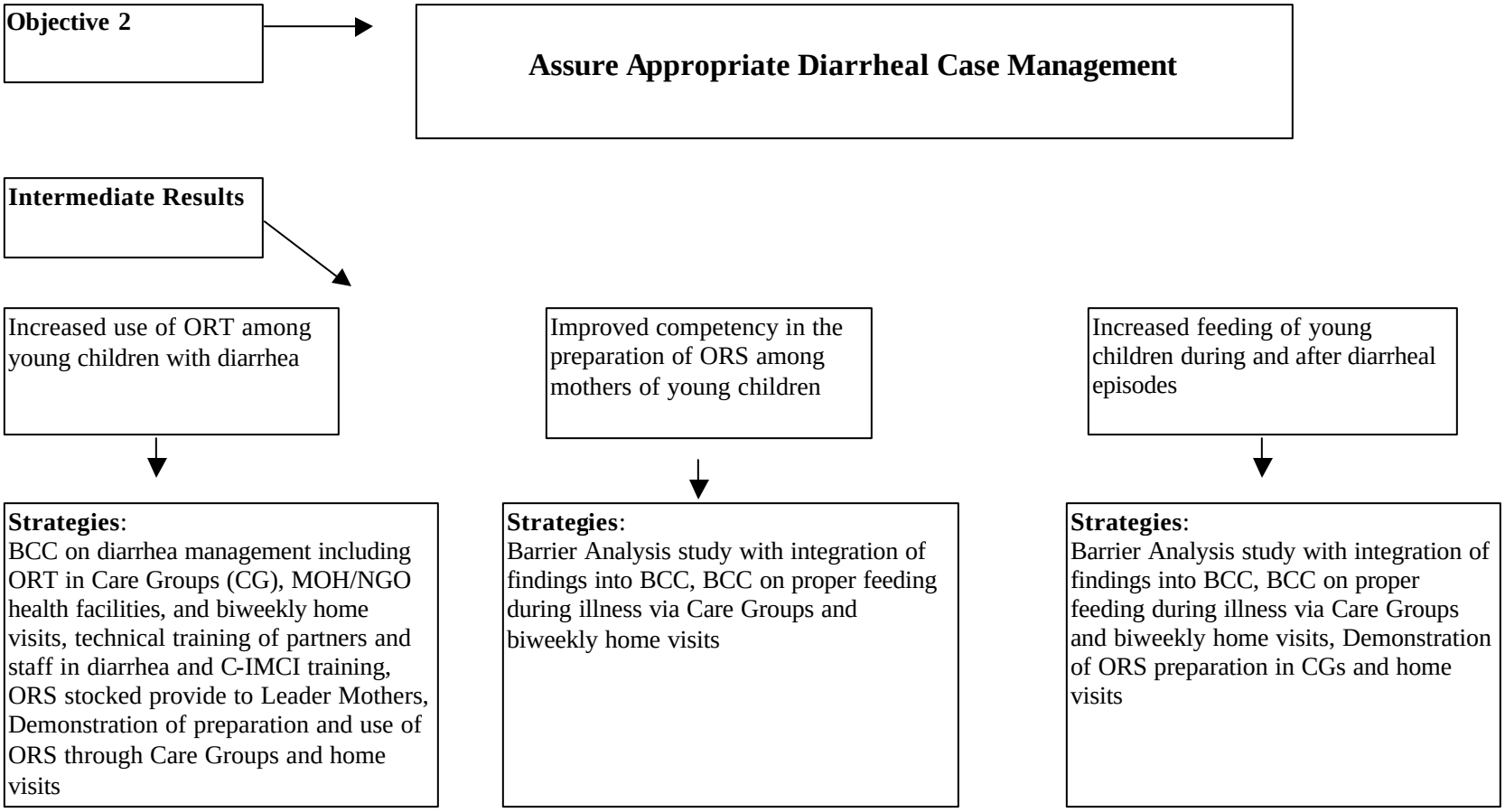
Furthermore this project will offer support in the achievement of the following CSHGP Program Results (PRs):

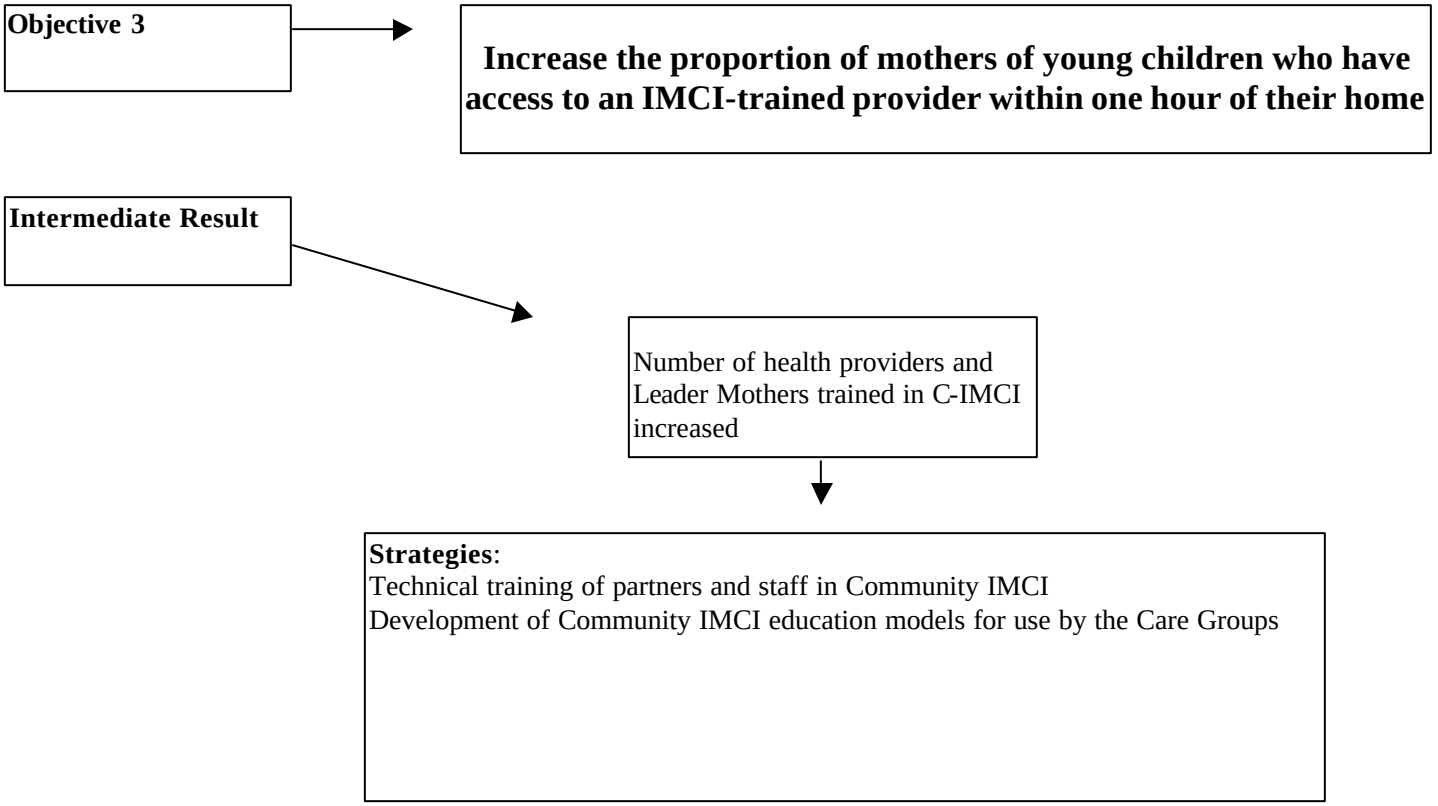
- *PR1: Increased use, coverage and quality of child and maternal health, and nutrition and infectious disease programs implemented by PVOs and their local partners:* FH will help the CSHGP meet this IR by increasing access to health promotion and community-level health workers trained in community/HH IMCI, and biweekly, high-quality CS health promotion in 55,703 households in Sofala province.
- *PR2: Increased sustainability of child and maternal health and nutrition and infectious disease programs/interventions initiated by PVOs and their partners*: Studies have shown that Care Groups are very sustainable in Mozambique as a means of maintaining gains made in health behavior change and coverage of essential health services.
- *PR3: Child and maternal health and nutrition and infectious disease program strategies, tools and approaches developed/adapted, tested and applied:* During this project, the innovative Care Group methodology, which is already under discussion by CORE and other child survival agencies, will be further tested and applied at the provincial level. FH plans to collaborate with World Relief (that is managing a

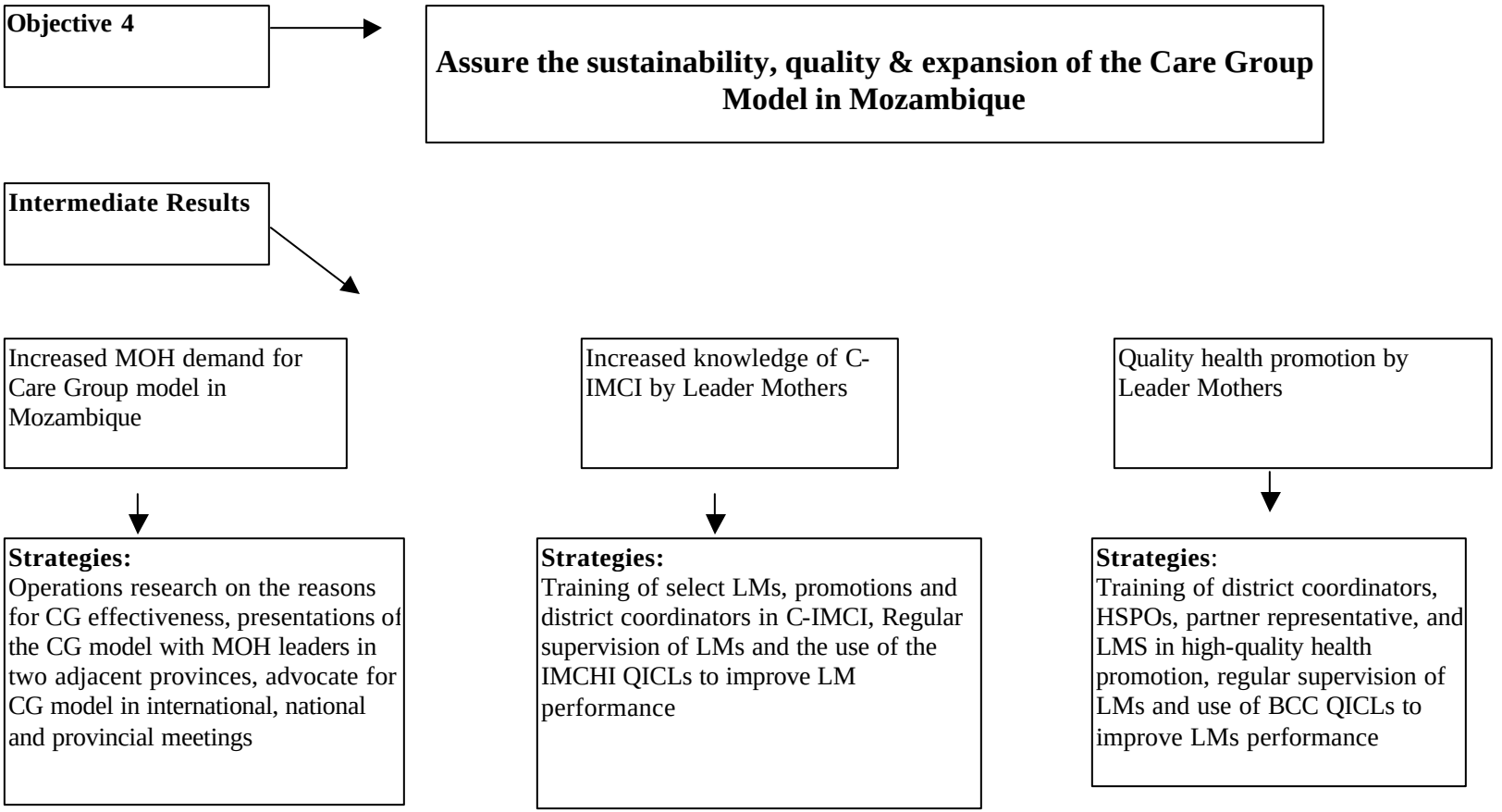
similar project in Gaza province) to document the effectiveness of Care Groups. The results of these programs will be used to advocate for the use of Care Groups as a national methodology to extend Community/HH IMCI in Mozambique. Funding for visits during the year to share lessons learned is included in the budget. FH has already collaborated with World Relief in the CORE-funded development of a Care Group manual and child mortality study in Care Group communities

A Results Framework is found on the next page.


Results Framework
1. Significantly reduce morbidity and mortality especially among children 0-23m of age and pregnant women – in Sofala district
2. Increase access to community and household IMCI-trained health providers in the program areas
3. Transfer the knowledge, skills, tools and passion needed for effective and sustainable community health development through the Care Group model to project partners in order to continue child survival activities once the project has ended
Objective 1
Goals
Intermediate Results
Improved Child Nutritional Status
Increased exclusive breastfeeding of children 0-5 mths of age
Increased feeding frequency of children 6-23 mths who are fed solid or semi-solid food at least 3 times daily
Increased proportion of young children fed nutrient dense foods
Increased proportion of children receiving vitamin A
Regular deworming of children increased
Increased participation in regular GM/P activities
Strategies:
BCC and nutrition promotion via Care Groups (CGs), GM/P through MOH health facilities, technical training of partner staff in nutrition (including breastfeeding promotion), Community IMCI training of Leader Mothers and Promoters, PD studies in each district (as part of Hearth), and Barrier Analysis to improve nutritional messages, integration of Motivational Interviewing into CG curricula.
Strategies:
BCC via home visits, Vit A supplementation, coordination between Promoters, LMs and health facilities to assure complete coverage. Promotion of the production of Vit A rich food through Agric. Extension and marketing networks in selected districts.
Strategies:
Education of mothers via home visits, deworming children >12m of age , coordination between Promoters, LMs and health facilities to assure complete coverage.
Strategies:
Promotion of monthly GM/P and NC via CGs staff, education of mothe via home visits, accompaniment of mothe to health facilities for GM/P.


Objective 2
Assure Appropriate Diarrheal Case Management
Intermediate Results
Increased use of ORT among young children with diarrhea
Improved competency in the preparation of ORS among mothers of young children
Increased feeding of young children during and after diarrheal episodes
Strategies:
BCC on diarrhea management including ORT in Care Groups (CG), MOH/NGO health facilities, and biweekly home visits, technical training of partners and staff in diarrhea and C-IMCI training, ORS stocked provide to Leader Mothers, Demonstration of preparation and use of ORS through Care Groups and home visits
Strategies:
Barrier Analysis study with integration of findings into BCC, BCC on proper feeding during illness via Care Groups and biweekly home visits
Strategies:
Barrier Analysis study with integration of findings into BCC, BCC on proper feeding during illness via Care Groups and biweekly home visits, Demonstration of ORS preparation in CGs and home visits


Objective 3
Increase the proportion of mothers of young children who have access to an IMCI-trained provider within one hour of their home
Intermediate Result
Number of health providers and Leader Mothers trained in C-IMCI increased
Strategies:
Technical training of partners and staff in Community IMCI
Development of Community IMCI education models for use by the Care Groups


Objective 4
Assure the sustainability, quality & expansion of the Care Group Model in Mozambique
Intermediate Results
Increased MOH demand for Care Group model in Mozambique
Increased knowledge of C-IMCI by Leader Mothers
Quality health promotion by Leader Mothers
Strategies:
Operations research on the reasons for CG effectiveness, presentations of the CG model with MOH leaders in two adjacent provinces, advocate for CG model in international, national and provincial meetings
Strategies:
Training of select LMs, promotions and district coordinators in C-IMCI, Regular supervision of LMs and the use of the IMCHI QICLs to improve LM performance
Strategies:
Training of district coordinators, HSPOs, partner representative, and LMS in high-quality health promotion, regular supervision of LMs and use of BCC QICLs to improve LMs performance

4. Program Monitoring and Evaluation Plan

a. Current information system in the target area

The Sofala provincial MOH collects information regarding clinical services (coverage) as part of the Sofala MOH monitoring system but does not collect community level data regarding knowledge and practices related to nutrition and diarrhea. Currently, the MOH monitors the number of children weighed, vitamin A supplements distributed, vaccines given and types of illnesses presented at health facilities. Both district and provincial MOH representatives have stated that there is no means of verifying the quality of this data. For the past few years the MOH has been attempting to develop a system of evaluating data quality but to date do not have such a system in place. The MOH has requested assistance and FH will explore ways to help them meet this need during the first year of the project.

FH is also developing various forms and M&E tools, such as Care Group registries and vital events reporting, that they will train both program and MOH staff to use throughout the life of the program. The MOH is very enthusiastic to receive FH data to include in their reports. FH will send MOH district copies of data collected by our Promoters (via tally sheet from CG Report Forms). These tally sheets include community level information regarding number of iron supplements, vitamin A and ORS packets distributed; immunizations; child deaths (disaggregated by age); births, number of CG teaching sessions conducted; number of LMs attending; number of screening posts held; children seen at screening posts and the nutritional status of children weighed during screening posts.

MOH staff will work closely with program staff in the supervision of Promoters and Care Groups and will serve as members of the CS Coordination Team during to monitoring all aspect of program implementation. Throughout the life of the program, FH will supply District, Provincial, and National MOH offices with copies of M&E and program reports.

b. M&E Plan – please see table below:

OBJECTIVE	INDICATOR	SOURCE/MEASURE METHOD	Freq. of Data Collection	Baseline Value	EOP Target
To decrease malnutrition (underweight) in children 0-23m	Percentage of children age 0–23 months who are underweight (WAZ<-2.0)	Anthropometry study	At Least Yearly[27]	26%	18%
To increase exclusive breastfeeding of children 0-5m	Percentage of infants aged 0-3 months [per MOH norms] who were fed breastmilk only in the last 24 hours	Semi-annual review of Behavior Box, Yearly Mini-KPC + baseline/ final KPCs	Semi-annual/ Yearly	17%	60%
To increase feeding frequency of children 9-23m who are fed solid or semi-solids food at least three times a day	Percentage of children 9-23m who receive food other than breastmilk at least three times per day [Nationally accepted indicator (Title II)]	Mini-KPC + baseline/final KPCs	At Least Yearly	33%	65%
To increase the proportion of young children fed nutrient-dense foods	Percentage of children 6-23 months of age with oil added to their weaning food [Nationally accepted indicator]	Semi-annual review of behavior box, Yearly Mini-KPC + base-line/ final KPCs	Semi-annual/ Yearly	35%	80%
To decrease VAD by increasing the proportion of young children who regularly consume vitamin A rich foods.	Percentage of children 6-23m who have consumed at least one vitamin A rich food in the previous day	Semi-annual review of Growth Charts, Yearly Mini-KPC + baseline/final KPCs	At Least Yearly	29%	80%
To decrease VAD by increasing the proportion of young children in Sofala who are regularly receiving vitamin A supplements	Percentage of children 12-23 months of age who have received one vitamin A capsule in the past six months	Mini-KPC + baseline/final KPCs	Semi-annual/ Yearly	82%	95%
To decrease helminthiasis and improve nutritional status by increasing the % of young children who are regularly dewormed	Percentage of children 12-23 months who received deworming medication in the last six months	Semi-annual review of CGs, Yearly Mini-KPC + baseline/final KPCs	Semi-annual/ Yearly	24%	75%
To increase the proportion of children 0-23m of age who participate regularly in growth monitoring/promotion activities	Percentage of children aged 0-23 months who were weighed in the last four months (card-confirmed)	Semi-annual review of CGs, Yearly Mini-KPC + baseline/final KPCs	Semi-annual / Yearly	70%	90%
To increase the proportion of young children with diarrhea who are given ORT in order to decrease dehydration and death	Percentage of children aged 0-23 months with diarrhea in the last two weeks who received oral rehydration solution (ORS) and/or recommended home fluids (RHF)	Mini-KPC + baseline/final KPCs	At Least Yearly	71%	90%

[27] Some indicators may be measured up to four times a year

OBJECTIVE	INDICATOR	SOURCE/MEASURE METHOD	Freq. of Data Collection	Baseline Value	EOP Target
To increase feeding of young children during diarrhea	Percent of children aged 0-23 months with diarrhea in the last two weeks who were offered the same amount or more food during the illness	Mini-KPC + baseline/final KPCs	At Least Yearly	31%	60%
To increase the proportion of mothers of young children who are competent in preparation of ORS	Percentage of mothers of children 0-23m who can correctly prepare ORS	Mini-KPC + baseline/final KPCs	At Least Yearly	44%	80%
To increase the proportion of mothers of young children who know when to seek care for sick children	Percentage of mothers of children age 0–23 months who know at least three signs of childhood illness that indicate the need for treatment	Mini-KPC + baseline/final KPCs	At Least Yearly	29%	75%
To increase the proportion of mothers who receive a vitamin A dose during the first two months after delivery	Percentage of mothers who receive a vitamin A dose during the first two months after delivery	Mini-KPC and final KPC (new indicator)	At Least Yearly	Not measured	80%
To increase the proportion of mothers able to report at least two known maternal danger signs during the postpartum period	Percentage of mothers able to report at least two known maternal danger signs during the postpartum period	Mini-KPC and final KPC (new indicator)	At Least Yearly	Not measured	80%
To increase the proportion of mothers receiving post partum iron supplements	Percentage of women who received iron during the post partum period following the birth of their youngest child	Mini-KPC and final KPC (new indicator)	At Least Yearly	Not measured	70%
Continue to expand usage and improve the Care Group model in Mozambique	The MOH in at least one other Mozambican province requests assistance (during the life of the program) from FH to expand the Care Group model into their geographical area. OR is conducted on the reasons for Care Group effectiveness.	Review of project documents	At Midterm	n/a	n/a
To increase to 80% the proportion of LMs trained in IMCI who can properly use the IMCI protocols for children 2-59m of age	% of Leader Mothers trained in community-IMCI modules who score 80% or higher on an IMCI QI checklist.	QI Checklist	Following Training + Yearly	n/a	80%

OBJECTIVE	INDICATOR	SOURCE/MEASURE METHOD	Freq. of Data Collection	Baseline Value	EOP Target
To increase to 80% the proportion of LMs who are able to do high-quality health promotion	% of Leader Mothers who score 80% or higher on the Health Promotion checklist (QIVC).	QI Checklist	Monthly	n/a	80%
Increase the capacity of local partners and 90% of project communities to effectively address local health needs.	% of first-phase Care Groups that continue to meet and do health promotion following reduction of health Promoter staff in Year 2.5.	Questionnaire for partners and community leaders.	Yearly, Years 3-5	n/a	90%

c. Data quality

Pre- and posttests will be used in all trainings of HPSO's and Promoters. This data will be used to measure the quality/effectiveness of trainings and to discover where further on-the-job training is needed.

Oral Testing in Care Groups: As interventions are phased in, Leader Mothers will be orally tested on their knowledge of key project messages during their biweekly Care Group meetings in order to reinforce their current learning and assess whether the group is able to carry out health promotion without further extensive involvement of the Promoter. If the average score in the group on the quiz exceeds 60%, the group celebrates and proceeds to the next lesson plan. Otherwise, the group returns to study the current lesson plan, stronger Leader Mothers are paired up with weaker ones for teaching, and the group is retested in a month. During the last year of the project, Promoters will conduct reviews of all the intervention lesson plans in all groups. Performance of LMs is also assessed and improved by the Promoter using QIV checklists (assessing both content and method used for health promotion). More information on FH's methodology for pre/posttesting can be found in the Title II **Monitoring Toolkit produced by FH technical staff at:** http://gme.fhi.net/fse/isapr/index.htm#mneToolKit.

Quality Improvement and Verification Checklists: QIVCs will be used by the HPSO's in their supervision of Promoters, and by the Promoters to supervise Leader Mothers. The data from these checklists have been used by FH to measure and improve the quality of key processes and interventions. (See Annex 12 for an example.) They are also used to measure the impact of trainings on fieldwork. FH's HQ technical staff have been heavily involved in QI activities and trainings, and have participated in the (former) CORE QI Working Group. Checklists for GM/P, individual counseling, IMCI, education, and other key processes will be used.. (This tool is described in more detail in the previously cited Monitoring Toolkit.)

The HPSO's will use random **spot checks** of growth charts of mothers in the Care Groups and compare that data to information reported by the Promoters. This data will be used to check the validity of the data reported by Promoters. They will also check the validity of oral quizes completed by the Promoters by re-testing 10% of groups. (The methodology for this is described in the previously-cited Monitoring Toolkit.)

d. Monitoring tools:

A intial **census** was conducted in Phase I communities and will occur in Phase II communities during year three of the program. This is an essential step in establishing the Care Groups that are central to this project's methodology. The census also includes a **retrospective study on child mortality** during the past year in households with preschool children. Project staff members and partners have used this data to get an idea of the pattern of child deaths (e.g., at what age children are dying from certain classifications of illnesses) so the interventions and contact schedule can be modified to

have more of an impact on mortality. (See Report on Baseline Assessments, Annex 12 for results from this study.)

Community-level Information System: Every two weeks during the Care Group meetings, each Leader Mother verbally reports on the status of the women and children in her twelve-group of households. This method allows for the inclusion of both literate and illiterate volunteers. One of the literate Leader Mothers is chosen by the group to be the President who is responsible for filling in the group's copy of the Care Group Report Form. This report form is a sheet for keeping track of pregnancies, births, deaths, and children who are malnourished, and children who have received key services (e.g., vitamin A). The presence of this locally-held report allows the MOH and other institutions to coordinate *directly* with the Care Group Leaders when organizing immunization posts and other health outreach activities in an area. The Promoter keeps a copy of this information in a duplicate Care Group Report Form (for each group). A tally sheet is used to to keep track of the current month's events and situations, and this information is reported to the HPSO during monthly meetings. HPSOs report to district-level MOH representatives and the CS Program Manager in Beira and who then provides monthly reports to the FH HQ backstop in Washington DC and the Director of Health Programs. The information is also aggregated and reported during quarterly Team Coordination Meetings. The data is used by Leader Mothers and health facility staff to inform others of children needing particular services (e.g., immunizations), to determine which mothers need encouragement to seek certain services (i.e., to guide health promotion), to track the number of child deaths, and to guage success locally. At the provincial level, the aggregated data from these report forms -- when used with the mini-KPC data -- can be used to monitor progress towards meeting targets (especially in terms of service provision) and problem areas.

Verbal Autopsies: Members of FH's Title II technical support team are versed in the use of verbal autopsies for preschool children. In this project, verbal autopsy forms will be filled out by Promoters for all children under two years of age who die during the project. This tool will enable the project partners to to analyze patterns of child mortality and make midcourse changes in project strategies in order to better target interventions and decrease child deaths. (This form is available upon request.)

FH will also use a **Behavior Box and Growth Chart**: This is a card that will be kept with each growth card. The data contained in it are used to monitor and document specific behaviors of the child's mother (e.g., exclusive breastfeeding) so that health workers can better understand the reasons behind patterns in a particular child's growth. An example of a behavior is found below.

Things to ask the mother during EACH VISIT.	Born: __/__ mon yr	0	1	2	3	4	5	6	7	8	9	10	11
Did you give your child colostrum when he was born?													
Are you currently breastfeeding?													
Are you currently giving your child any water, other liquids, food or anything else except breast milk?													
Are you presently giving your child solid or semisolid food?													
Are you currently adding oil to your child's food?													
Has your child had diarrhea during the past month?													
Has your child has cough/diff. breathing in the past month?													
Has your child had a fever during the past month?													
Has your child had any other illness in the past month?													

In addition to the Behavioral Box, FH will be testing a Star Mom card, to be place on the back of the Behavioral Box to keep track of mother's completing key child survival tasks. These tasks includes immunizations, exclusive breastfeeding, Vit A, deworming and water purification. An example of the Star Mom Card appears below, an X will be place on each box when the task has been completed.

 All Vaccines	 Exclusive BF	 Mother Knows Danger Signs
 Vitamin A #1	 Vitamin A #2	 Vitamin A #3
 Deworming #1	 Deworming #2	Mother Purifies Water

e. Data collection

Most Leader Mothers will not be responsible for collecting written data however they will verbally report on vital events, the number of beneficiaries they visited, success with health promotion and services that the children in their cohort have received.

The President of each Care Group will be responsible for maintaining the Care Group Report Form which includes information on vital events such as numbers of births, deaths, malnourished children, as well as information regarding beneficiary mothers.

Promoters will maintain a duplicate copy of each report form and will be responsible for a Tally Sheet (see **Annex 14** for an example) that includes aggregated information (for his/her five Care Groups) regarding total number of Care Group teaching sessions held; Lead Mother attendance during trainings; number of screening posts held and the number of children seen during screening posts; information regarding malnutrition disaggregated by age groups; number of children and pregnant women dewormed; number of Vitamin A doses administered; number of children receiving ORS packets; number of children immunized by the MOH during screening posts; number of pregnant women receiving tetanus toxoid; and information regarding the number of child deaths (disaggregated by age) during the month.. This information will be collected during bi-weekly Care Group meetings and Promoters will present monthly Tally Sheets to the HPSO's during their monthly district meetings as a way to summarize the activities that they have conducted.

Quarterly monitoring surveys (mini-KPC's), to coincide with the completion of training modules, will be conducted to collect more detailed information regarding the status of vaccinations, vitamin A supplements, deworming, malnutrition, and the adoption of key behaviors. For pregnant women, additional information regarding prenatal visits, iron supplements, as well as post-partum Vitamin A supplementation will also be collected.

HPSO's aggregate information and report monthly to the CSP Manager. The HPSO's also collect data regarding the performance of each Promoter. The CSP Manger will use this aggregated data to monitor progress towards meeting targets (especially in terms of coverage levels and nutritional status) and problem areas.

The CSP Manager will provide a report on program progress and results during quarterly CS Coordination team meetings. The CSP Manager will also submit monthly reports to the FH HQ backstop (a sample of the monthly CSP Manager monthly report can be found in Annex 15.) These monthly reports include information regarding the total number of Care Group meetings held; number of mothers educated; training conducted during the month – including topics, participants, and pre and post-test scores; stocks out of materials and/or medicines; nutrition activities and coverage; morbidity and mortality patterns; QICL scores; field visits by the CS Manager during the month; and activities planned for the following month. The FH HQ technical backstop and the Director of Health Programs will use this information to assess progress in implementing program strategies and to make modifications and improvements where necessary.

f. Data analysis and use during monitoring

The data from the HIS will be aggregated by the M&E Specialist and analyzed, and sent to the provincial MOH for their reporting and to the FH HQ for use in regular project reporting to USAID.

Furthermore the information collected via the Care Group will be used by Leader Mothers to tailor individual health lessons to the beneficiary mothers they serve.

The Care Group Presidents will look for trends in terms of Leader Mothers participating, and which Beneficiary Mothers are being visited and which are not, which services children need the most (in order to motivate beneficiary mothers to receive these services, such as Vitimin A supplements).

Promoter's will track tends in participation by Leader Mothers in Care Group training as well as trends in coverage and services – i.e. malnutrition screenings, deworming, immunizations, Vitamin A and ORS. Promoters will also look for trends in child deaths. Following the mini-KPC each year, Promoters will look at progress made with each indicator tracked via the mini-KPC and will devote more attention to those indicators that are moving slowly. LQAS data from the baseline survey is also being shared with Promoters so they know which of the indicators are most problematic for their district.

HPSOs in addition to tracking similar types of information as the Promoters, will also track the performance of Promoters via QIVCL and meetings with community leaders. They will also use the mini-KPC data and baseline LQAS data to will look at progress made with each indicator and will devote more attention to those indicators that are moving slowly in their district.

The CSP Manager will use program data to monitor the success of program interventions. The CSP manager will also monitor the work of all HPSOs and Program Promoters via monthly field visits.

The CS Coordination team will meet quarterly to discuss program results and activities and will provide general guidance and oversight throughout the life of the program.

g. On-going assessments:

FH will conduct an **abbreviated health facility assessment** in Manga district focusing on two key interventions – GM/P and diarrhea case management. HPSO's will use quality improvement checklists (QICL's) to assess the quality of these services at local health facilities. The results of these assessments will be communicated to the MOH as well as program partners – HAI and CUAMM – to assist in quality improvement. We will also encourage the MOH to conduct similar assessments in additional districts.

FH will conduct **Rotating Mini-KPCs** in project communities after the completion of training modules. FH's HQ technical team members have published on,[28] and trained other agencies in, this methodology. With this methodology, a short KPC-type questionnaire is administered yearly to a sample of mothers of children less than two years of age (all mothers from by one Care Group per Promoter, chosen without replacement). Anthropometry will be done regularly: Weight-for-age will be assessed at baseline, during the mini-KPCs, and at final. Data from these surveys help project staff/partners to monitor progress towards meeting targets (especially in terms of behavior change), and to identify problem areas. For a full description of the Mini-KPC methodology, see the Title II Monitoring Toolkit produced by FH technical staff at: http://gme.fhi.net/fse/isapr/index.htm#mneToolKit

Quality Improvement Checklists will be used by the HPSO's in their supervision of Promoters, and by the Promoters to supervise Leader Mothers. QICL provide a detailed check of health workers' performance on their key processes in order to monitor and improve their performance, identify "system problems," and to encourage them.

Barrier Analysis will be conducted when developing each training module. Food for the Hungry developed this approach to identifying overcoming barriers with the help and funding of CORE Barrier Analysis is a rapid assessment tool that can help community organizations identify why recommended healthy behaviors are reluctantly adopted or not adopted at all. These behavioral determinants are identified so that more effective behavior change communication messages, strategies and supporting activities can be developed. It focuses on eight determinants: perceived susceptibility, perceived severity, perceived action efficacy, perceived social acceptability, perceived self-efficacy, cues for action, perception of divine will, and positive and negative attributes of the action (i.e., the behavior).

FH will use Barrier Analysis to determine key messages and activities for nutrition and diarrhea management interventions. It will also be used throughout the life of the program for behaviors that have not changed very much in order to understand what is keeping people from making a particular change.

Focus Group Discussions will also be conducted in year one to supplement the KPC with qualitative data. This qualitative data will also help project staff and partners to learn more about beliefs, practices and health vocabulary of the local population.

h. M&E roles and responsibilities

The FH HQ technical backstop – Lauren Erickson-Mamane, MPH – and Tom Davis, MPH (Dir. of Health Programs) will provide a significant amount of M&E support to the field staff in Mozambique. Mr. Davis has worked with the CORE Monitoring and Evaluation Working Group, and was the lead author of the CSTS/CORE KPC 2000

---

[28] Davis, T.P., Jr. and Mobley, J. (2001). Review of Health and Agriculture Monitoring Tools for Title II Funded PVOs. Prepared for Food Aid Management (FAM).

Curricula and the FAM Title II Monitoring Toolkit.[29] Ms. Erickson-Mamane has conducted trainings in KPC Methods, LQAS, and QIVCs. She is currently a member of CORE's M&E working group. FH's technical team members have been leaders in the CS community in monitoring and evaluation of CS and Title II programs, have published manuals for USAID on monitoring and evaluation, and will transfer these skills to the partners in Mozambique during this project. FH HQ backstops will be responsible for developing KPC and mini-KPC questionnaires, providing KPC and analysis training, assisting in developing monitoring forms, conducting trainings for the FH/Mozambique program staff, and reporting program progress and results to CSHGP.

The M&E Specialist will be responsible for participating in KPC surveys and data analysis as well as providing supervision for the M&E Technician. The M&E technician will be responsible for day-to-day M&E activities: quarterly field visits to monitor program activities, development of monitoring forms, data analysis, developing KPC survey sampling frameworks, and monitoring program indicators and results.

i. Assessing and strengthening skill of M&E staff

Pre-test swill be used to assess the current capacity of the M&E staff prior to each training concerning M&E**.** The trainings related to M&E include:

- KPC survey training
- Quality Improvement
- Verbal Autopsy
- Mini KPC and anthropometry
- Epi Info and data analysis

During these workshops the M&E staff will gain skills in developing KPC questionnaires, developing sampling frameworks and conducting KPC surveys – to include selection of supervisors, interviewers, interviewees etc. During QIVC training, M&E staff will learn how to measure quality of key processes and gain skills in providing positive monitoring. They will learn how to conducting verbal autopsies for children 0-23 months of age. This tool will enable them to to analyze patterns of child mortality and make midcourse changes in project strategies in order to better target interventions and decrease child deaths. During mini-KPC and analysis training, M&E staff will learn to monitor changes in knowledge, practice and coverage of program beneficiaires.

j. Sustainability of M&E system

The hope is that the Care Group Presidents and Leader Mothers will learn to maintain information regarding the types of services needed by the mothers and children they serves as which mothers are being reached by health promotion. This information will be collected via Care Group registries.

---

[29] The Title II Monitoring Toolkit (Tom Davis, MPH and Julie Mobley, MSPH, authors) is available through Food Aid Management (FAM). See http://gme.fhi.net/fse/isapr/index.htm#mneToolKit or http://www.foodaid.org/worddocs/moneval/toolkit/FAMTIIMonitoringToolkit.ZIP.

The goal of the program is to have the MOH take over the role of Promoters once the program has ended. MOH representative will be involved in all program trainings and will participate in supervision of Promoters during the life of the program.

k. Operations research ideas that will be carried out

FH will contact universities in Mozambique and the U.S. to organize a study to document the reasons for the success of the Care Group model. The study will examine costs associated with the model, how different activities contribute to the success of the model (e.g., TA, QI), which nutrition actions seem to have the most impact on growth, and other elements.

As part of its Title II Institutional Capacity Building program, members of FH's HQ technical team will be visiting Sofala over the next four years to conduct several nutrition and nutrition-related studies. Key representatives from the Child Survival project staff (e.g., the HNP Manager, CSP Manager and M&E Specialist) will participate in the following studies (conducted by the DHP and consultants), as well:

- A study on the **effect of HIV/AIDS (and other chronic conditions) on nutrition and food insecurity**.
- A study on **general vulnerability assessment**.

A study on **localized determinants of malnutrition has already been carried out** (in January 2005). **This** expanded stand-alone PD study examined depression in the mother[30], intake of specific nutrients,[31] domestic abuse, alcoholism among family members, and other potential causes of malnutrition. The results of this study can be found in **Annex 12** and will be used when choosing or developing key nutrition messages, curricula, and activities for this project.

CSHGP program results

This project will offer support in the achievement of the following CSHGP Program Results (PRs):

- *PR1: Increased use, coverage and quality of child and maternal health, and nutrition and infectious disease programs implemented by PVOs and their local partners:* FH will help the CSHGP meet this IR by increasing access to health promotion and community-level health workers trained in community/HH IMCI, and biweekly, high-quality CS health promotion in 55,703 households in Sofala province.
- *PR2: Increased sustainability of child and maternal health and nutrition and infectious disease programs/interventions initiated by PVOs and their partners*: Studies have shown that Care Groups are very sustainable in Mozambique as a

---

30 See Carvalhaes MA and Benicio MH. (2002). Mother's ability of childcare and children malnutrition. Rev Saude Publica 36(2):188-97.

31 See Golden, M.H. (1988) The role of individual nutrient deficiencies in growth retardation of children as exemplified by zinc and protein. Linear Growth Retardation in Less Developed Countries. Waterlow, J.C. (ed.). pp. 143-163. New York:Raven Press.

means of maintaining gains made in health behavior change and coverage of essential health services.

- *PR3: Child and maternal health and nutrition and infectious disease program strategies, tools and approaches developed/adapted, tested and applied:* During this project, the innovative Care Group methodology, which is already under discussion by CORE and other child survival agencies, will be further tested and applied at the provincial level. FH plans to collaborate with World Relief (that is managing a similar project in Gaza province) to document the effectiveness of Care Groups. The results of these programs will be used to advocate for the use of Care Groups as a national methodology to extend Community/HH IMCI in Mozambique. Funding for visits during the year to share lessons learned is included in the budget. FH has already collaborated with World Relief in the CORE-funded development of a Care Group manual and child mortality study in Care Group communities

l. USAID mission program results

This CS program is consistent with USAID/Mozambique's SO8 of the Country Strategic Plan for 2004-2010: "Increased use of child survival and reproductive health services in target areas". The Intermediate Results for this objective are (1) increased access to quality child survival and reproductive health services in target areas, (2) increased demand at community level for child survival and reproductive health services, and (3) more accountable policy and management. USAID Mozambique's goal is "broad-based rapid economic growth sustained through expanded capacities and opportunities." This child survival program will help USAID to meet these strategic objectives by greatly increasing access to quality CS services, and demand at the community level for CS services, by extending community and household IMCI and the Care Group structure to ten districts of Sofala provinces.

These contribution will be communicated to the mission via regular communication between CSP Manager Emma Hernandez, and Dr. Titus Angi with the USAID Mission in Mozambique. The CSP Manager will also fly to Maputo several times a year for meeting with the Mission. Furthermore FH will supply the mission with a copies of our annual project reports that will include the results of annual mini-KPC surveys.

m. For TB programs – Not Applicable

n. Evaluation plan

Midterm and final evaluations will be conducted consistent with USAID's guidance.

At baseline, LQAS and parallel sampling were used in Phase I districts to accurately select nine lots of 19 mothers each for two questionnaires (one for 0-11m old and one for 12-23m olds, with sick child questions in both in order to assure an adequate sample size). This data was used to inform project stakeholders – including community leaders – on the current health situation in each district, to determine which districts are in the most need of attention. Baseline data was also used to establish final levels for indicators. Key project data from the KPC will be shared with communities through the

use of locally-understandable graphs distributed through the Care Groups structure (as part of each module). Leader Mothers will educate their neighborhoods and communities on their situation using these same graphs. After two years, the project staff and partners will conduct a baseline survey in the second set of five districts phased in during Year Three using current staff.

At final, one lot of 19 mothers each for each of the ten districts will be used (with parallel sampling of 0-11 and 12-23m olds) and the same questionnaire will be administered along with anthropometry. Data analysis will be done using Epi-Info ver. 6.04d using the same program from baseline which includes cross-tabulations of important variables, with emphasis given to identifying factors related to nutritional status, child's gender, and age of the mother.

A full description of our baseline survey is included in section 2 of the DIP and Annex 12.

Program Management

Organizational Structure: FH will direct, mentor and work through its partners in Mozambique, to build their capacity to administer and technically manage the health activities conducted through the Care Group structure established by each district office. The proposed supervision and financial management structure is illustrated in the organizational chart in **Annex 6**. FH will maintain close contact with the USAID Child Survival office, provide project guidance and backstopping, manage the US-portion of the budget, and oversee the completion of USAID narrative and financial reporting requirements. FH will be responsible for receiving/dispersing all funds.

A **CS Coordination Team** will meet each quarter and will be responsible for the coordination and planning of activities in each district. This team will be comprised of FH staff, provincial MOH representative, representatives from HAI, CUAMM, and PWCSA. Once activities for the upcoming period have been decided upon by the CS Coordination Team, the CSP Manager is responsible for communicating them to all Health Program Support Officials (HPSOs) twice a week via cell phones, and during monthly visits to each district. There will also be monthly **District Coordination Meetings** that will be attended by the HPSOs , Promoters, and representatives from district level MOH. Partners will also install Groove software (see www.groove.net) to share files and coordinate plans, and use Elluminate Live, a "virtual classroom", which allows participants to 'meet' and communicate with others in the 'class' (even over a dial-up connection).

Food for the Hungry, the Sofala and the Provincial MOH will be the main field facilitators of this project. FH will hire a total of five HPSOs responsible for the ten districts included in the project. The CSP Manager and Provincial MOH representatives will coordinate together to supervise technical aspects of their work related to this project. Following the pattern used in FH's previous work with Care Groups, the HPSOs

will be responsible for biweekly supervision of approximately ten (paid) Promoters per district. On a quarterly basis, the MOH district staff will joint the HPSOs in their supervision of the Promoters (both during the project period and afterwards). As the project proceeds, the District MOH staff will take a greater role in the supervision functions. The HPSOs will be accountable to the CSP Manager. Each Promoter, in turn, is responsible for educating and supervising the work of the LMs in the five Care Groups that they serve. The PWSCA will motivate its network of volunteers in each district to participate in and aid the Care Groups established in each district. Details of authority/accountability are outlined in written agreements between FH and its partners in found in Annex 4.

It is estimated that Leader Mothers will spend about two hours ever other week participating in Care Group meetings. In addition to the Care Group meetings, LM's will conduct home visits to the 12 beneficiary mothers they serve therefore devotion on average 8 hours a week to this program.

Lauren Erickson-Mamane, MPH is FH's Child Survival and Nutrition Programs Coordinator and will be responsible for the primary technical and administrative backstopping to the field staff, and will travel to Mozambique 2-3 times each year. She will dedicate 42% of her time to this project in Year One, and 35% of her time in subsequent years. Lauren has over six years of international development experience and ten years of project management experience in strategic planning, administration, supervision, and project evaluation both overseas and in the U.S. Lauren has conducted trainings in KPC methodology and Lot Quality Assurance Sampling. **Tom Davis, MPH**, is **FH's Director of Health Programs (DHP)** and will dedicate 38% of his time to the project in Year One, and 30% of his time assisting in backstopping in subsequent years**.** Mr. Davis has worked with CORE, and 18 PVOs in the child survival community for 18 of the past 21 years, and was hired full-time with FH on10/1/04 after serving as a part-time consultant to FH for seven years. Mr. Davis has been integrally involved with the management of the Care Groups project for the last six years in Mozambique and has presented on the model at CORE, APHA, and other scientific meetings. He will travel to Mozambique approximately two to three times each year.

Emma Hernandez Avilan, BSN is FH/Mozambique's full time Child Survival Program Manager and is responsible for managing the CS team in Mozambique. Ms. Hernandez has ten years experience in training health workers during in Angola. Her expertise includes organizing, planning, training, and managing community health programs with emphasis on Maternal and Child Health. Ms. Hernandez will supervisor the CS HPSOS and will also provide guidance to the M&E Specialist in terms of the HIS and quality improvement and verification methods. **Mr. Tesfaye Legesse** will serve as the M&E Specialist for this project, and is the current M&E Program Manager for FH/Mozambique. Mr. Legesse has extensive experience in coordinating the design, planning, implementation and monitoring and evaluation of food security and integrated community development projects; he has provided leadership to seven food security and community development projects totalling over US$4 million. **Derrick Capurana** will serve as the M&E technician for this program and has been part of the FH/Mozambique

M&E team for the past three years. Mr. Capurana is experienced with KPC surveys, monitoring and evaluating health and nutrition programs, data analysis, survey report writing, and training of staff.

The HQ Child Survival and Nutrition Programs Coordinator and Director of Health Programs will be in regular communication with the CSP Manager, M&E Specialist and M&E Technician.

FH will be responsible for supervising the completion of process goals and final indicators. Progress toward objectives at the community level will be monitored jointly by the HPSOs and MOH district personnel, aided by the M&E Specialist (Tesfaye Legesse) and the M&E Technician who report to him and travel between districts on a regular basis. The M&E Specialist is directly accountable to the Country Director, but will liaise with the CSP Manager and HNP Manager, as well. The data from the HIS will be aggregated by the M&E Specialist and analyzed, and sent to the provincial MOH for their reporting, and to the FH HQ for use in regular project reporting to USAID. Monthly project technical and quarterly financial reports sent from the CSP Manager to FH's DHP will constitute the basis of FH's quarterly and annual reporting to USAID. This will include internal auditing by field staff and a yearly external audit. Internet service for the project office in Beira is reliable, and is used for frequent communications and document transfer. Shortwave radio communication is already being used in the project area by FH and will be extended to all ten project districts to facilitate project coordination. All HPSOs are provided with cell phone to further increase communication capabilities.

FH's Child Survival and Nutrition Programs Coordinator (CSNPC) (at 35%) will be responsible for the primary technical and administrative backstopping to the field staff. She will be assisted by FH's Director of Health Programs (at 30%). The DHP and CSNPC will ensure transfer of skills through several mechanisms. (1) The DHP and CSNPC will each conduct trainings and participate in curricula development with field staff in Mozambique three times a year. This will include training in KPC methodology, LQAS, supervision & quality improvement, and Epi-Info 3.2, as well as participating in curricula design. (2) The CSNPC will send summaries of relevant information from the CORE listserv and working groups, technical newsletters, USAID correspondences, and relevant training opportunities to project staff members. (3) The DHP and CSNPC will send information from technical updates and lessons learned during CS meetings in Washington to the CSP Manager and HNP Manager.

5. Organizational Development (for Entry/New Partner Grantees) not applicable

6. Training Plan

Please see training table below:

TRAINING TABLE

MOH = Ministry of Health; **HAI** = (Local NGO); **CUAMM** = (Int'l NGO), **PWCSA** = (Moz. Gov Organization); **AISPO** = (Int'l NGO); **DHP** = Dir. of Health Programs (HQ backstop**);** **CSNPC** = Child Survival & Nutrition Programs Coordinator (HQ Backstop); **HNP Manager** = Health & Nutrition Program Manager; **CSP Manager** = Child Survival Program Manager; **M&E Spec.** = Monitoring and Evaluation Specialist; **M&E Tech** = M&E technician; **HPSO** = Health Program Support Official ; TBA = Traditional Birth Attendant; **CG** = Care Group; **LM** = Leader Mothers; **HH** = Household

Training	Days	People	Participants	Trainers	When
CS Startup Workshop	3	22	FHI Country Director, HNP Manager, CSP Manager, M&E Spec, Financial Mgr, Human Resource Mgr, Administrative Assistant, 4 HPSOs , 5 district MOH reps, 2 CUAMM reps, HAI rep, PWCSA rep, Salvation Army Rep, translator,	DHP, CSNPC, CSP Manager, HNP Manager	December 2005
Staff orientation and basic administrative training (in-house)	4	4	3 HPSOs, Office Assistant	CSP Manager (input from HNP)	December 2005
Census and community mapping training	2	30	30 Promoters	3 District HPSO	January 2006
Baseline Survey (KPC): Training in Beira for KPC CORE Team	4	2	CSP Manager, M&E Tech	HNP, M&E Spec.	February 2006
Baseline Survey (KPC): District-level trainings of Interviewers and Others	3	16	3 HPSOs, 10 interviewers, 1 provincial MOH rep, 1 Supervisor/Translator, Administrative Assistant	CSP Manager, M&E Tech,	February 2006
KPC Analysis training	2	15	CSP Manager, M&E Spec, M&E Tech, 3 HPSOs, 4 district MOH reps, 1 translator, Administrative Assistant, AISPO rep, HAI rep, PWSCA rep	DHP	March 2006
DIP workshop	5	10	CSP Manager, M&E Tech, 3 HPSOs, Administrative Assistant, AISPO rep, HAI rep, PWSCA rep, CUAMM rep	CSHPC	March 2006
Orientation workshops for Promoters/partner staff on selection of LMs, working w/CGs, use of HIS, and overview of interventions.	3	44 (in 2 groups	30 Promoters, 3 HPSOs, M&E Tech, HAI rep, AISPO rep, PWCSA rep, CUAMM rep, provincial MOH rep, 5 district MOH reps	CSP Manager, 3 HPSO	April 2006
CG Module #1: Being a Leader Mother: CG/LM role, how to work with communities, BCC skills, vital events reporting, maintenance of CG Report Form, etc.	5	43 (divided into 2 groups)	3 HPSO, 30 Promoters, 5 district MOH reps, 1 Provincial MOH rep, HAI rep, AISPO rep, PWSCA Rep, CUAMM rep	CSP Manager	June 2006
Supervision/CQI Training/Verbal Autopsy	5	44 (divide into 2 groups)	M&E Tech., 3 HSPOs, 30 Promoters, 10 MOH/HAI/PWCSA/AISPO/CUAMM	CSP Manager & M&E Spec (with input from DHP)	June 2006
Community/HH IMCI TOT for HSPOs and Promoters	6 (48 hrs)	43	3 HPSOs, 10 MOH/ HAI/PWCSA/AISPO/CUAMM, 30 Promoters	MOH IMCI Trainer, CSP Manager	Sept 2006
LMs trained on Module #1	n/a	2,100	All LMs, trained during CG Meetings during two-month period	Promoters	July - August 2006
Beneficiary Training, Module #1	n/a	25,200 HH	All LMs, trained during CG Meetings during three-month period		July – August 2006
Community IMCI trained HSPO and Promoters begin training selected LMs in C-IMCI in each district	48 hours	150	One mother per CG trained over four weekends (8 days), trained in groups of 30, ongoing, throughout project.	HPSOs and Promoters, & MOH IMCI trainers	August 2006 and afterwards

Training	Days	People	Participants	Trainers	When
CG Module #2 on Sanitation & Hygiene: Disposal of excreta, latrines, hand washing, chlor. of water, cholera prev., food prep. and storage; deworming, etc.	5	43	3 HPSOs, 10 MOH/ HAI/PWCSA/AISPO/CUAMM, 30 Promoters	CSP Manager	Sept 2006
Training of LMs on Module #2	n/a	2,100	All LMs, trained during CG Meetings during three-month period	Promoters	October - December 2006
Beneficiary Training, Module #2	n/a	25,200 HH	All mothers of 0-23m olds and pregnant women trained	Leader Mothers	October - December 2006
Mini-KPC & Anthropometry Workshop	5	48	DHP, CSNPC, CSP Manager, M&E Spec., M&E Tech, 3 HPSO, 30 Promoters; 10 MOH/ HAI/PWCSA/AISPO/CUAMM	DHP, CSHPC, HNP Manager, CSP Manager, HSPOs	Beg Feb 2007
Data Analysis Workshop	5	17	DHP, CSNPC, CSP Manager, M&E Spec, M&E Techs., 3, HPSOs, 5 MOH reps, 4 HAI/PWCSA/AISPO/CUAMM reps	DHP	Mid Feb 2007
CG Module #3 on Diarrhea: Prevention and recognition of dehydration / ORT / dietary manag./ dysentery/persistent diarrhea / bloody diarrhea	5	43	3 HPSOs, 10 MOH/ HAI/PWCSA/AISPO/CUAMM, 30 Promoters	CSP Manager	End Feb/Beginning March 2007
Training of LMs on Module #3	n/a	2,100	All LMs, trained during CG Meetings during three-month period	Promoters	Mid March-Mid May 2007
Beneficiary Training, Module #3	n/a	25,200 HH	All mothers of 0-23m olds and pregnant women trained	Leader Mothers	Mid March – Mid May 2007
CG Module #4 on Breastfeeding: Initial BF/colostrum, Exclusive BF, persistent BF, not using bottle, advantages of BF, resolving BF problems, etc.	5	43	3 HPSOs, 30 Promoters, & 10 MOH/HAI/PWCSA/AISPO/CUAMM reps	CSP Manager	End of May 2007
Training of LMs on Module #4	n/a	2,100	All LMs, trained during CG Meetings during three-month period	Promoters	June – July 2007
Beneficiary Training, Module #4	n/a	25,200 HH	All mothers of 0-23m olds and pregnant women trained	Leader Mothers	June – July 2007
CG Module #5 on Comp. Feeding: Introd. of comp. foods: Nutritionally-dense foods, PD practices, freq. of feeding, serving sizes, GM/P, overview of Hearth, referral of sev. malnourished children, etc.	5	43	3 HPSOs, 30 Promoters, & 10 MOH/HAI/PWCSA/AISPO/CUAMM reps	CSP Manager	End of July 2007
Training of LMs on Module #5	n/a	2,100	All LMs, trained during CG Meetings during four-month period	Promoters	Aug – Sept 2007
Beneficiary Training, Module #5	n/a	25,200 HH	All mothers of 0-23m olds and pregnant women trained	Leader Mothers	Aug – Sept 2007
CG Module #6 on Micronutrients: micronutrient-rich foods, Vitamin A supp. for children and p/p women, tx with Vitamin A	5	43	3 HPSOs, 30 Promoters, & 10 MOH/HAI/PWCSA/AISPO/CUAMM reps	CSP Manager	End of Sept 2007
Training of LMs on Module #6	n/a	2,100	All LMs, trained during CG Meetings during two-month period	Promoters	Oct – Dec 2007
Beneficiary Training, Module #6	n/a	25,200 HH	All mothers of 0-23m olds and pregnant women trained	Leader Mothers	Oct – Dec 2007
CG Module #7 on Nut. during Pregnancy: Nut. messages for pregnant women, necessary nutrients, micronuts., iron supp., danger signs during pregnancy	5	43	3 HPSOs, 30 Promoters, & 10 MOH/HAI/PWCSA/AISPO/CUAMM reps	CSP Manager	Mid Feb 2008
Training of LMs on Module #7	n/a	2,100	All LMs, trained during CG Meetings during two-month period	Promoters	End Feb-March 2008

Training	Days	People	Participants	Trainers	When
Beneficiary Training, Module #7	n/a	25,200 HH	All mothers of 0-23m olds and pregnant women trained	Leader Mothers	End Feb – March 2008
Catch up training for LM and BM needing review on modules based on post test scored	n/a	n/a	All LMs and BM trained during CG Meetings	Promoters & Leader Mothers	April – May 2008
Review training on Modules 1-7 for Phase I Care Groups	n/a	27,300	All LMs and BM trained during CG Meetings	Promoters & Leader Mothers	June 2008 – May 2010
TOT for Hearth Nutritional Rehab Method (Year 3)	5	79	5 HPSO, 56 Promoters, 11 District MOH reps, 1 Provincial MOH rep, HAI/CUAMM/AISPO/PWCSA reps.	CSP Manager (input from DHP)	April-June 2008
Phase I Promoters teach LMs review modules on nutrition and diarrhea, and add. modules on malaria, HIV/AIDS, MNC; LM teach beneficiary mothers these lessons	n/a	27,300	All 2,100LMs trained during CG Meetings and all 25,200mothers of 0-23m olds and pregnant women trained	Promoters & Leader Mothers	June 2008 – Sept 2010, monthly
Phase II Promoters and LMs follow the same pattern of trainings and Modules shown above	n/a	35,490	All 2,730 Phase II LMs trained during CG meetings and all 32,760 mothers of 0-23m olds and pregnant women in Phase II districts trained	Promoters & Leader Mothers	April 2008 – Sept 2010
Mini-KPC & Anthropometry Workshop	5	49	5 HPSO, 39 Promoters, 5 district MOH reps	DHP, CSHPC, HNP Manager, CSP Manager, HSPOs	June 2008
CG Module #1: Being a Leader Mother: CG/LM role, how to work with communities, BCC skills, vital events reporting, maintenance of CG Report Form, etc.	5	49	5 HPSO, 39 Promoters, 5 district MOH reps	CSP Manager	July 2008
Supervision/CQI Training/Verbal Autopsy	3	49	5 HPSO, 39 Promoters, 5 district MOH reps	CSP Manager, M&E Tech	July 2008
LMs trained on Module #1	n/a	2,730	All LMs, trained during CG Meetings during three-month period	Promoters	Aug – Sept 2008
Beneficiary Training, Module #1	n/a	32,760 HH	All mothers of 0-23m olds and pregnant women trained	Leader Mothers	Aug – Sept 2008
Community/HH IMCI TOT for HSPOs and Promoters	9	46	2 HPSO, 39 Promoters, 5 MOH reps	MOH trainer	Beginning of Dec 2008
Community IMCI trained HSPO and Promoters begin training selected LMs in C-IMCI in each district	8	195	195 Leader Mothers – one mother per phase II Care Groups	Promoters	Dec 2008 and thereafter
CG Module #2 on Sanitation & Hygiene: Disposal of excreta, latrines, hand washing, chlor. of water, cholera prev., food prep. and storage; deworming, etc.	5	46	2 new HPSO, 39 Promoters, 5 district MOH reps	CSP Manager	End of Sept 2008
Training of LMs on Module #2	n/a	2,730	All LMs, trained during CG Meetings during three-month period	Promoters	Oct – Nov 2008
Beneficiary Training, Module #2	n/a	32,760 HH	All mothers of 0-23m olds and pregnant women trained	Leader Mothers	Oct – Nov 2008
CG Module #3 on Diarrhea: Prevention and recognition of dehydration / ORT / dietary manag./ dysentery/persistent diarrhea / bloody diarrhea	5	46	2 new HPSO, 39 Promoters, 5 district MOH reps	CSP Manager	End of Feb – beg March 2009
Training of LMs on Module #3	n/a	2,730	All LMs, trained during CG Meetings during three-month period	Promoters	Mid March – Mid May 2009

Training	Days	People	Participants	Trainers	When
Beneficiary Training, Module #3	n/a	32,760 HH	All mothers of 0-23m olds and pregnant women trained	Leader Mothers	Mid March – Mid May 2009
CG Module #4 on Breastfeeding: Initial BF/colostrum, Exclusive BF, persistent BF, not using bottle, advantages of BF, resolving BF problems, etc.	5	46	2 new HPSO, 39 Promoters, 5 district MOH reps	CSP Manager	End of May 2009
Training of LMs on Module #4	n/a	2,730	All LMs, trained during CG Meetings during three-month period	Promoters	June – July 2009
Beneficiary Training, Module #4	n/a	32,760 HH	All mothers of 0-23m olds and pregnant women trained	Leader Mothers	June – July 2009
CG Module #5 on Comp. Feeding: Introd. of comp. foods: Nutritionally-dense foods, PD practices, freq. of feeding, serving sizes, GM/P, overview of Hearth, referral of sev. malnourished children, etc.	5	46	2 new HPSO, 39 Promoters, 5 district MOH reps	CSP Manager	End of July 2009
Training of LMs on Module #5	n/a	2,730	All LMs, trained during CG Meetings during three-month period	Promoters	Aug – Sept 2009
Beneficiary Training, Module #5	n/a	32,760 HH	All mothers of 0-23m olds and pregnant women trained	Leader Mothers	Aug – Sept 2009
CG Module #6 on Micronutrients: micronutrient-rich foods, Vitamin A supp. for children and p/p women, tx with Vitamin A	5	46	2 new HPSO, 39 Promoters, 5 district MOH reps	CSP Manager	End of Sept 2009
Training of LMs on Module #6	n/a	2,730	All LMs, trained during CG Meetings during three-month period	Promoters	Oct – Nov 2009
Beneficiary Training, Module #6	n/a	32,760 HH	All mothers of 0-23m olds and pregnant women trained	Leader Mothers	Oct – Nov 2009
CG Module #7 on Nut. during Pregnancy: Nut. messages for pregnant women, necessary nutrients, micronuts., iron supp., danger signs during pregnancy	5	46	2 new HPSO, 39 Promoters, 5 district MOH reps	CSP Manager	End of Feb 2010
Training of LMs on Module #7	n/a	2,730	All LMs, trained during CG Meetings during three-month period	Promoters	April – March 2010
Beneficiary Training, Module #7	n/a	32,760 HH	All mothers of 0-23m olds and pregnant women trained	Leader Mothers	April – March 2010
Catch up Trainings for LM and BM needing review on certain modules based on post test scores	5	46	2 new HPSO, 39 Promoters, 5 district MOH reps	CSP Manager	May 2010
NEW CG MODULES	5	76	5 HPSOs, 56 Promoters, 15 MOH/AISPO/ HAI/PWSCA/CUAMM rep	CSP Manager	June 2010 – Sept 2010
New modules for both Phase I and Phase II LM	n/a	4,830	All Phase I and Phase II LM's trained on new modules	Promoters	June 2010 – Sept 2010
Beneficiary Training New Modules	n/a	57,960	All mother of 0-23 m olds and pregnant women trained	Leader Mothers	June 2010 – Sept 2010
Lessons Learned Workshop for PVOs, NGOs, MOH, and other Stakeholders	1	30	CSP Manager, M&E Spec, M&E Tech, 10 district MOH reps, 1 prov. MOH Rep, 5 HPSO 1 AISPO, 1 HAI rep, 1 PWCSA rep.,1 CUAMM rep, 7 other NGO/PVO reps.	CSP Manager, DHP, CSNPC, Participants	Sept 2010

7. Work Plan and Table

	Year 1		Year 2				Year 3				Year 4				Year 5			
Activity	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q3**	**Q1**	**Q2**	**Q3**	**Q4**
PHASE I DISTRICTS IN SOFALA																		
Elaboration of DIP	X																	
Orientation for Promoters	X																	
Finish forming the Care Groups	X																	
Revising and testing Care Group Module 1	X																	
CSP mgr in US	X																	
Supervision/CQI/Verbal Autopsy Training	X																	
Training of HPSOs, Promoters, MOH and partners on **Module 1 Care Group Orientation**	X																	
Phase I Promoters train LM on Module 1, LMs do health promotion on Module 1		X																
Revise and pre-test Module 2		X																
Community HH/IMIC TOT for HPSO and Promoters		X																
Community IMCI trained HPSO and Promoters begin Training Slected LMs in C-IMCI in each district		X																
Training of HPSOs, Promoters, MOH and partners on **Module 2 Sanitation and Hygiene**		X	X															
Phase I Promoters train LM on Module 2, LM do health promotion on Module 2			X															
Annual review meeting of Project Partners; Devel. of Year #2 Annual Implementation Plan & Use/ Analysis of Verbal Autopsies Workshop (FHI HQ Backstop visit)			X															

	Year 1		Year 2				Year 3				Year 4				Year 5			
Activity	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q3**	**Q1**	**Q2**	**Q3**	**Q4**
Revise and pre-test Module 3			X															
Mini KPC and anthropometry as well as KPC workshop and data analysis workshop				X														
Training of HPSOs, Promoters, MOH and partners on **Module 3**				X														
Phase I Promoters teach LMs on Module #3; LMs do health promotion on **Module #3**				X	X													
Revision and pretesting of Care Group **Module #4: Breastfeeding**			X	X														
Training of Phase I District Coordinators and Promoters in Care Group Module #4					X													
Phase I Promoters teach LMs on Module #4; LMs do health promotion on Module #4					X	X												
Revision and pretesting of Care Group **Module #5: introduction of Complementary Foods**					X													
Training of Phase I District Coordinators and Promoters in Care Group Module #5						X												
Phase I Promoters teach LMs on Module #5; LMs do health promotion on Module #5						X												
Revision and pretesting of Care Group **Module #6: Micronutrients**						X												
Training of Phase I District Coordinators and Promoters in Care Group Module #6						X												
Phase I Promoters teach LMs on Module #6; LMs do health promotion on Module #6							X											
Annual review meeting of Project Partners & Devel. of Year #3 Annual Implementation Plan (FHI HQ Backstop visit)							X											
Revision and pretesting of Care Group **Module #7: Nutrition and Care for Pregnant Women**						X												
Mini-KPC & anthropometry for Year Two								X										
Training of Phase I District Coordinators and Promoters in Care Group Module #7								X										

	Year 1		Year 2				Year 3				Year 4				Year 5			
Activity	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q3**	**Q1**	**Q2**	**Q3**	**Q4**
Phase I Promoters teach LMs on Module #7; LMs do health promotion on Module #7								X										
Catch up on modules									X									
Mid term evaluation									X									
PHASE II DISTRICTS IN SOFALA																		
KPC, FGDs, and Barrier Analysis studies.									X									
Selecton of Phase II Promoters and formation of Community Development Committees									X									
Community mapping and census activity									X	X								
Identification of Leader Mothers and formation of Care Groups									X	X								
TOT for District Coordinators and Promoters on **Hearth Nutritional Rehabilitation Methodology**;									X									
TOT for other partners on **Hearth Nut. Rehab Methodology**									X									
Begin Hearth Methodology & PD studies in project communities									X									
Mini-KPC & anthropometry workshop (Phase II staff)										X								
Supervision/CQI/Verbal Autopsy Training										X								
Training of HPSOs, Promoters, MOH and partners on **Module 1 Care Group Orientation**										X								
Phase II Promoters train LM on Module 1, LMs do health promotion on Module 1										X								
Training of HPSOs, Promoters, MOH and partners on **Module 2 Sanitation and Hygiene**										X								
Phase II Promoters train LM on Module 2, LM do health promotion on Module 2											X							

	Year 1		Year 2				Year 3				Year 4				Year 5			
Activity	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q3**	**Q1**	**Q2**	**Q3**	**Q4**
Annual review meeting of Project Partners & Devel. of Years #4 & 5 Annual Implementation Plan (FHI HQ Backstop visit)											X							
Community HH/IMIC TOT for HPSO and Promoters											X							
Community IMCI trained HPSO and Promoters begin Training Slected LMs in C-IMCI in each district											X							
Mini KPC and anthropometry year 4												X						
Training of HPSOs, Promoters, MOH and partners on **Module 3 Diarrhea**												X						
Phase II Promoters teach LMs on Module #3; LMs do health promotion on **Module #3**												X	X					
Training of Phase I District Coordinators and Promoters in Care Group Module **#4 Breastfeeding**													X					
Phase II Promoters teach LMs on Module #4; LMs do health promotion on Module #4													X	X				
Training of Phase I District Coordinators and Promoters in Care Group Module **#5: introduction of Complementary Foods**														X				
Phase II Promoters teach LMs on Module #5; LMs do health promotion on Module #5														X				
Training of Phase I District Coordinators and Promoters in Care Group Module **#6 Micronutrients**														X				
Phase II Promoters teach LMs on Module #6; LMs do health promotion on Module #6															X			
FINAL KPC																X		
Final Evaluation																	X	X
Training of Phase I District Coordinators and Promoters in Care Group Module #7 **Nutrition and Care for Pregnant Women**																X		
Phase I Promoters teach LMs on Module #7; LMs do health promotion on Module #7																X	X	

	Year 1		Year 2				Year 3				Year 4				Year 5			
Activity	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q3**	**Q1**	**Q2**	**Q3**	**Q4**
Catch up on modules for Phase II																	X	
New module for Phase I and Phase II Promoters, LM and BM																	X	X
Lessons Learned Workshop for PVOs, NGOs, MOH, and other Stakeholders																		X
Hearth Screenings									X		X		X		X		X	
Barrier Analysis			X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	
Coordination with Partner and MOH	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Monthly HPSO and Promoter Meetings	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
CS coordination team quarterly meetings	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X

9. Revised Budget and Budget Narrative:

[Please see separate file]

Budget Narrative

Changes from the proposal budget: please note that most all of the line items have changed given changes in project districts, some improvements in staffing, and changes in transportation means available in new districts

I. Field Staff: Given that this project will be carried out in ten districts of Sofala province, we plan to phase in interventions and district/community-level workers in project areas, starting in five districts of Sofala, and then extending to five additional districts in Sofala. During the second phase (commencing Year 2.5), the number of Promoters used to cover the first set of districts will be dropped by half, and the remaining Promoters will visit Care Groups on a monthly rather than biweekly basis.

- *CS Program Manager*: The CS Program Manager will be paid for out of FH's cash match. We have budgeted for an expatriate (Ms. Emma Hernandez, BSN).
- *M&E Specialist and Technicians*: This is the current salary level for Mr. Tesfaye Legesse (an Ethiopian national) who currently holds this post in FH/Mozambique. Mr. Legesse will devote 13% of his time to this project, and will be assisted by an M&E technician who will devote 80% of his time. They will not start billing their time on the project until during the 3rd month, therefore working 9 out of 12 months during year 1.
- *HSPOs*: Each district will have a HSPO who is a qualified health worker. There will be three HPSOs in Phase I (all of whom worked on the Title II Care Group project – hence the varying pay grades) and two will be added in Phase II (mid-point of Year 3), bringing the total to five of the LOP in both provinces.
- *Promoters*: Thirty will be hired to work in the 5 districts of Sofala in the first phase. In the mid-point of Year 3, there will be 39 new Promoters hired for the five additional districts in Sofala bringing the total number of Promoters to 69 for the LOP. They will not be hired during the first months but will hired in the 4th month of the project. Therefore working 8 out of 12 months during year 1.
- *Drivers*: One drive will be hired to support program activities. They will not be hired during the first months but will hired in the 3rd month of the project. Therefore working 9 out of 12 months during year 1.
- *District Team Leaders*: District Team leaders support FH programs at the district level and will dedicate 13% of their time to this program. There will be 2 District Team leaders responsible for Phase I districts and another 2 will be added in Phase II. They will not be hired during the first months but will hired in the 4th month of the project. Therefore working 8 out of 12 months during year 1.
- Community Team Leader: The CTL is part of the District team and will dedicate 12% of his/her time to this program. Will not be hired during the first months but will hired in the 4th month of the project. Therefore working 8 out of 12 months during year 1.
- *Community Development Leader*: Is part of the District team and will dedicate 10% of his/her time to this program. Will not be hired during the first months but will hired in the 4th month of the project. Therefore working 8 out of 12 months during year 1.
- *District Logisticians*: District logistician will dedicate 7% of their time to this program – 2 in phase I and 4 in Phase II. Will not be hired during the first months but will hired in the 4th month of the project. Therefore working 8 out of 12 months during year 1.

- *Guards*: Three guards will be hired for this program for both provincial and district offices. Will not be hired during the first months but will hired in the 7th month of the project. Therefore working 5 out of 12 months during year 1.
- *Trainer* – a full time trainer will be hired to develop program curricula and train program staff. Will not be hired during the first months but will hired in the 7th month of the project. Therefore working 5 out of 12 months during year 1.
- *Key Personnel to Include in Cooperative Agreement:* FH has hired a Child Survival and Nutrition Programs Coordinator, Lauren Erickson-Mamane, MPH who will serve as the HQ technical backstop for this project at 42% for year one and 35% thereafter. FH's Director of Health Programs, Tom Davis, MPH who will provide backstopping support at 38% during the first year and 30% thereafter. The CSP Manager will be Emma Hernandez, BSN. Mr. Tesfaye Legesse will serve as the M&E Manager.

II. Field Staff Fringe: Expenses for fringe are included for field and HQ staff, based on FH's current fringe benefits for Title II staff, which is in line with the USAID Mozambique Mission's Compensation Plan. **The fringe rate for FH expatriate staff (CSP Manager and M&E Specialist) in Mozambique for the project will amount to 100.0% of salary. For all other field staff, it is based on 25%%of salary.** The breakdown of the local benefits is as follows:

- Resettlement allowance, 50% of one month's salary = Salary*0.04166
- Social Security, 4%
- Bonus, 1 month salary = Salary*0.08333
- Medical, $300/year
- Termination Benefits 12.5%

The breakdown of expatriate field staff benefits is:

- 12% Medical
- 5%, Pension
- 2.5%, liability insurance
- 44% Housing and security guard:
- 14% Housing maintenance and utilities
- 18% Mileage
- 3.3% Local medical related costs
- 2.2% School fees for dependents

Yearly increases in salaries: Our yearly increases in salary are in line with or slightly below those used by other PVOs in Mozambique: 5% per year. The CSP Manager's fringe costs are covered out of match.

III. HQ Staff: Includes the Director of Health Programs (Tom Davis, MPH) project at 38% during year 1 (when project activities are more intense) and 30% years 2-5, the Child Survival and Nutrition Programs Coordinator (Lauren Erickson-Mamane, MPH) who will be the HQ backstop for this program devoting 42% of her time during year 1 and 35% thereafter. The yearly increase in the backstop salary is based on the average inflation rate in the U.S. for the period 1992-2001 [2.7%[32]] plus a small yearly increase to yield a total of 5%. The Director of Health Program's salary will be paid with matching funds.

---

[32] See http://www.eh.net/ehresources/howmuch/inflationq.php. inflation rate.

IV. HQ Fringe: **The fringe for FH's HQ staff is 22%. For HQ, the breakdown of the fringe rate is:**

- Medical/vision/dental/life ins. 9.35%
- Pension 5 %
- FICA 7.65%

Total Benefits = 22.0%

The Director of Health Program's fringe will be paid with matching funds.

V. Field Travel -

The following corresponds to numbered items in the budget in Section V.:

A. International Air Transportation

CSP Manager, Colombia - Mozambique, one way
CSP Manager, Colombia - Mozambique roundtrip for home leave. This will be paid with matching funds. If CSP Manager decides not to renew her contract at this time, this line item would provide for flying a newly hired CSP manager to Mozambique
CSP Manager, Mozambique to Nairobi for regional continuing education opportunities trainings, not yet identified. This expense will be paid out of match.
CSP Manager to US for DIP review workshop in Baltimore. This will be paid with matching funds.

B. Domestic Air Travel

1. CSP Manager to Maputo: Funds are requested to permit the CSP Manager to attend coordination meetings in Maputo with the national MOH, USAID, World Relief and other PVO representatives (for policy advocacy), and other functions twice a year. (More trips to Maputo will be made, but the airfare for these flights will be covered through other grants.)

C. Ground Transportation – PLEASE NOTE the number of participants in trainings reflected in the training table in Section 7 of the DIP is slightly lower than the number of individuals receiving transportation and food and lodging as shown on budget. This is due to the fact that the budget includes costs associated with drivers needed to transport training participants

1. **CS Startup Workshop:** Funds are requested for transportation for 22 participants (stakeholders and project staff – see training table in **Section 7 of the DIP**) to the two-day CS startup workshop from different parts of the project area to Beira where the workshop will be held. The cost is based on 300,000 Meticais each way, or $12.50 per participant.
2. **Orientation Training for Promoters and Partners,** A 3-day orientation training for Promoters and partners will be held in Year 1 in the five districts phased in during the first 2.5 years, and in Year 3 for the remaining five districts. Please refer to the Training Table for a list of participants. Transportation costs (pick up by project vehicle – as there are no reliable public transportation options in most of the program districts) are based on transportation costs within each district amounting to $23.90 roundtrip per person. Trainings will be held at several district locations.

3.-9. **Trainings on each Care Group Module:** Five-day trainings on each Care Group Module (#1 through #7) will be provided at the district level. In the first phase of the project, each workshop will be attended by the 30 Promoters in Phase I districts, plus 3 HSPOs, and 10 MOH/PWCSA/HAI/CUAAM/AISPO representatives and two trainers (CSP Manager and CS Trainer). In phase two, each workshop will be attended by the 39 Promoters included in phase two, 5 HPSOs, 5 MOH representatives (one per new district), and two trainers. Transportation costs (pick up by project vehicle – as there are no reliable public transportation options in most of the program districts) are based on transportation costs within each district amounting to $23.90 roundtrip per person. Trainings will be held at several district locations.

10. **Training on additional module:** training of all 56 Promoters active during Phase II, 5 HPSO and 15 MOH/PWCSA /HAI/CUAAM/AISPO representatives, trainers will be CSP manager and CS trainer. Transportation costs (pick up by project vehicle – as there are no reliable public transportation options in most of the program districts) are based on transportation costs within each district amounting to $23.90 roundtrip per person. Trainings will be held at several district locations.

11. **Hearth Nutritional Rehabilitation Workshops for Promoters/HPSOs and Partners:** A five-day training on how to conduct Hearth nutritional rehabilitation workshops at the community level through the Care Group structure will be conducted in Year 3 of the project with all of the 56 Promoters active in the second phase of the program plus the 5 HSPOs and 15 MOH/NGO reps.. Workshops will be held at the district level. Transportation costs (pick up by project vehicle – as there are no reliable public transportation options in most of the program districts) are based on transportation costs within each district amounting to $23.90 roundtrip per person.

12. **C/HH IMCI Training-of-Trainers:** A 48 hour TOT on IMCI will be held in each district for all Promoters (30 in Year One, and 39 in Year 3) plus the HSPO and three partner representatives (from either the MOH or CUAAM) in each district. Transportation costs (pick up by project vehicle – as there are no reliable public transportation options in most of the program districts) are based on transportation costs within each district amounting to $23.90 roundtrip per person.

13. **C/HH IMCI Training of Leader Mothers:** One Leader Mother per Care Group (150 in phase one and 180 in phase two) will receive a 48 hour training in C/HH IMCI at the district level (facilitated by the trained HSPO and Promoters). Transportation costs (pick up by project vehicle – as there are no reliable public transportation options in most of the program districts) are based on transportation costs within each district amounting to $23.90 roundtrip per person.

14. **Supervision/CQI Training, Verbal Autopsy Training:** District-level, five-day trainings on supervision and CQI and Verbal Autopsies will be provided for staff and partners. (See Training Table for a list of participants.). Transportation costs are based on public transportation costs within each District amounting to $23.90 roundtrip per person.

15. **Analysis Software Training:** A five-day workshop for 15 project staff members and partners (see list in Training Table) on analysis software (e.g., Epi-Info 3.2) will be held in the first year of the project and conducted by the DHP and CSNPC. This workshop will be held in Beira and the average transportation costs per participant will be $25.00

16. **Mini KPC/Anthropometry Training:** A five-day workshop for 49 people in year 1 and an addition training for 53 people in year 3. This workshop will be held in Beira and the average transportation costs per participant will be $25.00

17. **Lessons Learned Workshop:** A one-day Lessons Learned Workshop will be held in the final year of the project for 30 participants. This workshop will be held in Beira, some participants will be coming from Beira, some will be using program vehicles, some will provide for their own transportation (e.g., PVO/NGO representatives from other areas of the country) the average transportation cost per participant is $25.

18. **Trips from Provincial Offices to Districts and within Beira by the CSP Manager and M&E Specialist:** These visits will be for coordination and supervision of the work in each district. During each visit, the CSP Manager and M&E Specialist will visit several districts in order to visit each district quarterly. Costs are based on 3,778 km per trip to the districts x $0.45/km x 1 trips per quarter (4 trips phase I and then 8 phase II to accommodate 1 trip per quarter for each of phase I and phase II districts.

19. **Trips from Districts to Prov. Office by HPSO**: Trips by 3 HSPOS in phase I and 5 HPSOs in phase II to FH HQ in Beira for quarterly meetings with the CS Manager. Costs based on average of 1,644 KM * $0.45/km.

20. **Trips by Promoter/HPSOs to monthly district meetings**. – Trips by Promoters and HPSOs to districts for monthly team meetings– average transportation cost, using project vehicles is $19 per participants per month.

21. **Materials transport to Phase I Districts:** Project supplies must be physically transported to each district in large trucks. Funds are requested for two trips per month in each of the five district during phase I, this will be reduce to 1 per month half way thru the project. The cost is based on $740 per trip (1,644 km * $0.45/km)

22. **Materials transport to Phase II Districts** Project supplies must be physically transported to each district in large trucks. Funds are requested for two trips per month in each of the five districts during phase II. The cost is based on $740 per trip (1,644 km * $0.45/km – km for Phase II are estimated, actual km's will be calculated once we have entered these districts.

C. Per Diem- PLEASE NOTE the number of participants in trainings reflected in the training table in Section 7 of the DIP is slightly lower than the number of individuals receiving transportation and food and lodging as shown on budget. This is due to the fact that the the budget includes costs associated with drivers needed to transport training participants.

1**. CS Startup Workshop:** The costs per day for this workshop are $35.40 per participant per day, based on costs for hosting a workshop in Beira from previous Title II experience.

2.-14 & 16 **Staff and Partner Orientation, Trainings on each Care Group Module, Hearth Methodology, C/HH IMCI TOT and Leader Mothers, Supervision/CQI, Verbal Autopsy, & Mini-KPC/Anthropometry Trainings:** All of these trainings will be held at the district level. Lengths of each of the trainings are given in the budget and the narrative above. Costs are based on previous Title II experience for workshops held in districts $25.09/day/ participant

15. **Analysis Software Training:** Funds are requested to cover meals, breaks, and guesthouse lodging for this training at $35.40/day (based on previous Title II experience).

17. **Lessons Learned Workshop:** Funds are requested to cover lunch and two breaks as well as lodging for this training at $35.40/day.

18. **Food/lodging during CSP Manager and M&E Specialist trips to Districts:** Funds are requested to cover food/lodging for these trips (described above) --$22/day.

19. **Food/lodging during HSPO trips to Beira:** Funds are requested for $17 per trip – based on calculations for lunch, dinner, snacks and lodging form previous Title II experience

20. **Monthly District Coordination Meetings:** Funds are requested for these monthly meetings. These will be attended (in each district) by the Promoters, HSPOs, MOH/NGO reps, and sometimes the M&E Technicians.

21-22 **Supervision trips by HPSOs to non-home districts, Phase I & II:** Funds are requested for food and lodging for HPSOs when they are doing supervision in their non-home district. In Phase I, one HPSO will travel from Caia (home district) to Chemba and one HPSO will travel from Marromeu (home district) to Maringue. The cost in Phase I is $265.42 per person per month. In Phase II, one HPSO will travel from Gorongosa (home district) to Nhamatanda and another HPSO will travel from Manga (home district) to Dondo, and a third HPSO will travel from home district (Marromeu) to three other districts (Meringue, Caia, and Chemba). The cost in Phase II is $959.58 per month for all HPSOs.

VI. HQ Travel

A. International Transportation

1. **Backstop Visits to Mozambique:** HQ travel includes visits from U.S. (Charlotte or Greensboro, NC) to Beira, Mozambique for onsite training and support each year by the Director of Health Programs and Child Survival and Nutrition Programs Coordinator. Both of these people will make two trips during year 1. In year two, the CSNPC will make three trips and the DHP will make two trips. For all subsequent years, both the CSNPC and DHP will make two trips per year. Roundtrip tickets from WDC or Greensboro to Mozambique are estimated to be $2,200/trip. This is based on a recent quote from MTS Travel (FH's travel agency). These trips will be covered by match.

B. Domestic Air Transportation

1. **DHP to WDC for Meetings**: Four trips to WDC from Greensboro, NC for the DHP based on a quote by US Airways. These trips will be covered by Match.

C. HQ Per Diem

1. Costs for CSNPC food during trips to Mozambique are based on 10-day trips at $40/day ($40 per day for food and incidentals – CSNPC will lodge with FH/Moz staff). These estimates are based on recent experience during travel to Beira by CSNPC
2. Costs for DHP food and lodging during trips to Mozambique are based on 12-day trips at $90/day (includes lodging at a Beira hotel). These estimates are based on recent experience during travel to Beira by DHP. Per diem for years 1-3 will be cover by USAID direct and by matching funds in years 4 & 5

3. Food/lodging for the four annual trips to HPSO are calculated at $200/day for three days per visit. FH reimburses based on receipts, and this is less than the 2004 GSA maximum rate for WDC.

VII. Field and HQ Equipment – No field or HQ equipment purchases are planned within this proposal.

VIII. Field Supplies – HSPOs will require a number of items in support of their roles as trainers and supervisors:

- **Helmets, boots, and rain jackets** are essential gear for frequent travel into the field.
- The **backpacks** included in the supplies are low-cost ones that need to be replaced each year. They will be used to carry materials during field visits.
- **Logo shirts** are included as a way of identifying the HPSOs associated with this project.
- **Paper, markers, pens, etc.:** These will be used during the regular functioning of each district office, and also during trainings. This is based on $100/month per district office and is consistent with charges incurred by FH in its Title II Care Group project.
- **Desk, chair, filing cabinet:** FH will be required to purchase some furniture for each HSPO. Prices are based on local purchase in Beira.
- **Cell phones** will also be used for communication between districts and from districts to the office in Beira. (We will have access to the shortwave radios in MOH facilities as a backup.) We have budgeted $25/month per HPSO for cell phone minutes, and these will be covered under match.
- **Water canteens** are covered under match.
- **Motorcycles, helmets and associated equipment:** These will be purchased with matching funds and are the HSPOs chief means of transportation within and between districts. The cost is based on a quote of $4,273.50 ($5,000 less VAT of 17%).
- **Desktop computers and UPSs:** Funds are requested for desktop computers for each Health Program Support Officer, the lead FH health staff at the district level. They will use these computers to do their reports, statistical analysis, correspondence, etc.
- **Photocopies, HIS/Training forms etc. –** cost of $43.80 per district/month.
- **Fuel for HPSOs –** average cost of $91.00/month for each HPSO in Phase I (based on 3,900 km/month for all three HPSOs @ 1 liter / 20 km * $1.40 per liter) and an average cost of $140/month for each HPSO in Phase II (based on 2,000 km/month for each of the 5 HPSOs @ 1 liter/20 km * $1.40 per liter).

Promoters Materials:

- **Backpacks, boots, and rain jackets** are essential gear for frequent travel into the field
- **Watches** for counting respirations (done when managing children using the IMCI protocols) will be given to each Promoter as they are phased in.
- **Logo shirts** are included as a way of identifying the Promoters associated with this project, and will paid using matching funds.
- **Child weighing scales** will be used in the screening posts, and will be requested via UNICEF. The cost of these is based on $24.45 per balance which include shipping (quoted from UNICEF).
- **Bicycles, tubes, and maintenance:** These will be the Promoters chief means of transport to the Care Groups that they serve. Each Promoter is based in the area of their

Care Groups, so distances can be traversed by bicycle. From FH's past experience in Title II, these bicycles must be replaced at least once a year. (FH has tried to use more expensive mountain bikes, but found that they do not last longer than the cheaper bikes included in this project.)

- **IMCI Chart book:** This is the set of plasticized sheets with the IMCI protocols used when evaluating and classifying sick children. These will be requested from WHO.
- **Register books:** These are blank notebooks used to keep project records and documentation.
- **Cooking utensils for Hearth:** Each Promoter will receive a $7.00 set of simple cooking utensils that are used during the Hearth nutritional rehabilitation program.
- **Flipcharts:** These are the flipcharts that are used by the Promoters during their educational sessions with each Care Group at a cost of $17.50 per module.

M&E Staff and Trainer Materials:

- **Laptop Computers and camera:** Two laptop computers – one for the M&E Technician and one for the Trainer – will be purchased in Year One as well as a camera that will be used to take pictures that will be included in FH publications and also for use in the flipcharts used by FH Promoters and the Leader Mothers. Cost is based on a Dell Lattitude D610 priced online on April 10th.

Leader Mothers' Materials:

There are 2,100 Leader Mothers included in phase one of the project, and 2,730 Leader Mothers added in phase two (beginning Year 2.5) for a total of 4,830

- **Uniform for Leader Mothers:** Each Leader Mother will be given a wrap-around skirt with health messages and designs on them after two years of active service. This is a traditional incentive used in Mozambique by government agencies, political parties, and other PVOs. FH has used these successfully in its Title II program as a small incentive for mothers to regularly carry out their home visits to mothers and pregnant women in their charge. Costs are based on a recent quote in Beira which is the same cost as that charged during the Title II health program that used Care Groups. These will be paid for out of match. These will be covered by match in years 2 & 3 and USAID direct in years 4 & 5.
- **Flipcharts for education of Mothers:** Each Leader Mother (2,100 in Year 1 and an additional 2,730 in Year 3) will receive eight small flipcharts, one per educational module plus the additional module in year 5 of the program. During phase I FH will be using color flipcharts Cost of one module is based on quote of $4.50 for 20 page of color print. During Phase II Costs of one module is based on a quote of $2.60 for 20 pages of black and white print (given budget constraints we were not able to budget for color flip charts during both phases. This will allow us to test if there is any difference between color and black and white flip charts. During our successful Title II Care Group program, black and white flip charts were used. We think there may be a benefit to using color.)
- **IMCI Chart books:** This is a set of plasticized sheets with the IMCI protocols used when evaluating and classifying sick children. One is included per each Leader Mother trained in IMCI (one LM per Care Group). These will be requested from the WHO. We have requested USAID funds to cover IMCI chartbooks in Year one, and they will be covered by matching funds in Year three.

- **Care Group Report Form:** This form that contains the majority of information that is collected on children and pregnant women represented by each Care Group.
- **Child Weighing Scales –** each Care Group will receive a child weighing scale to be used in the screening posts, and will be requested via UNICEF. The cost of these is based on $24.45 per balance which include shipping (quoted from UNICEF).

Office/Training Supplies and Software:

- **Photocopies and HIS forms:** These costs are based on two sheets per Care Group per month and ten sheets per district per month at $0.10 per copy. Costs for photocopying of training materials, etc., are included in the district costs above ("paper, markers, pens, etc.")
- **Paper, pens, newsprint, OVP sheets, misc. office supplies:** This includes all of the office materials used by the field HQ offices in Beira. The cost of $200/month is based on past experience with FH's Title II health program.
- **Cell phone minutes for CSP Manager, Trainer, and Driver:** The CSP Manager and Trainer both receive $25 a month in cell phone minutes for project communication. The driver receives $6.25/month for cell phone minutes. The average yearly cost for these three to use cell phones is $225/person.
- **Laptop for CS Manager, flashdrive, UPS, printer:** Funds are requested for one laptop, flashdrive, UPS and printer for Year 1 and a replacement laptop in Year 3. Our experience is that laptops need to be replaced every few years when operating in – and transported in – this harsh environment.
- **Cell phone handsets:** Funds are requested for cell phone handsets for the CSP Manager, 5 HPSOs, the Trainer, and a Driver. These are used for project communication.
- **Filing cabinet:** An additional file cabinet will be needed for the Beira office in order to maintain documents for this project.

(Prices for all of the above materials are based on the project staff's experience with purchasing these items as part of their current Title II project activities.)

IX. HQ Supplies: Office supplies are budgeted to support the Director of Health Programs (HQ backstop) Child Survival and Nutrition Programs Coordinator These supplies include:

- **Paper, pens, misc. office supplies** for use in backstopping the project, including:
  - Xerox Primary Image Copy Paper, one box, $31.99
  - HP TwinPack Inkjet Cartridges, HP C6578AN High Capacity TriColor Ink Cartridge, $54.99 x 4 = $219.96
  - HP TwinPack Inkjet Cartridges, HP C6650AN Blister Twin Pack, $52.99 x 4 = $211.96
  - Vision Elite Black Rollerball Pen, 4Pk, $7.99 x 6 = $47.94
  - Assorted Sizes Binder Clips, $2.59 x 3 = $7.77
  - Tape, 1" core, ¾" x 650", $1.88 x 2 = $3.76
  - Report covers, Navy Flexi-View Report Covers, $4.99 for 2 pk x 4 = $9.98
  - Large envelopes, Tan self-sealing bubble-lined envelopes, 10 ½ x 15, $4.49 for 5 pack x 4 = $19.52
  - Stamps, $0.34 each, 5 booklets of 20 = $34.00
  - Highlighter, Stabilo, $1.79 x 4 = $7.16
  - Glue stick, $1.09 x 2 = $2.17

- Liquid Paper all-purpose Correction Pen, $3.79 for 2 pack x 1 = $3.79
- ***(All of these prices are based on a quote from www.officedepot.com.)***
- Total = $600.00 per year and will be covered by matching funds.

- **Laptop Computer:** in year 3 laptops will be purchased for the DHP and CSNPC – cost of $2,195 each based on quote for a Dell Precision M65 for a total cost of $4,390.These will be paid with matching funds
- **Software**: $200/year has been included for new software and software updates during the life of the project (e.g., MS Office 2006). This will be purchased using matching funds.
- **Portable Printer:** $160.00 for a HP Deskjet portable printer. This will be purchased with matching funds.

X. Contractual, Field:

- **Audit:** FH will contract with an AID approved auditing firm each year to conduct the Mozambican portion of the AID required "single audit." We expect to pay $3,000 for this each year, based on previous audits of Title II programs.
- **Midterm Evaluation Consultant and Costs:** Costs for the midterm evaluation, estimated at $10,000 based on previous Title II health program evaluation costs.
- **Final Evaluation Consultant & Other costs:** $15,927.92, based on cost of mid-term plus $5,927.92 for additional activities and length of time. This will be covered under match.
- **Care Group Effectiveness Study:** FH will seek matching funds or partner donated time (e.g., from universities) to conduct a study on the effectiveness of Care Groups (as outlined in the M&E section of the proposal).
- No consultants or other contractual services will be used in this project.

XI. Contractual, HQ:

- FH will contract with a consultant to **translate draft education modules from English to Portuguese** – quote is based on approximately nine pages (5,060 words) at $150/1000 words. These drafts will be created at headquarters in consultation with Mozambican staff and partners, translated to Portuguese, and finalized in Mozambique (in Portuguese). These translations will be covered under match.

XII. Other Direct Field Costs:

- **Allocable Direct Costs:** FH has a letter from James Deery, Chief, Overhead and Special Cost Branch at AID/FA/OP/PS/OCC (Room 1432, SA-14) dated February 8, 1993 concerning the allocable direct costs line item. (Available upon request) This letter outlines how FH uses the allocable direct costs line item for direct program expenses in Mozambique which cannot be clearly and easily allocated to particular programs. This line item is approximately 21% of USAID funds that will be received during this project. FH requests that USAID cover this line item. FH will cover (as a match) the allocable direct costs on its share of the direct costs.
- **Baseline KPC survey and DIP workshop:** The Baseline KPC costs will include:
  - 10 interviewers x 8 days = 11 US= 880 USD
  - 8 Supervisors: 8days X11US= 440 USD
  - 3 Drivers x 8 days x 11= 264 usd

- Training materials for KPC TOST: $260
- Food/lodging for KPC team members during training in Beira: 5HSPOs (Supervisors) + 2 M&E Technicians + CSP Manager + 9 partner staff = 21 people x $37.08/day x 3 days = $2,336.04
- Travel to/from Beira for training: $12 per person x 18 people = $216
- Interviewer Training at district level: 10 interviewers + 1 M&E technicians + 5 HSPOs (Supervisors) + 10 partner staff = 26 people x $22/day (food/lodging) x 3 days = $1,716
- Analysis Workshop (district level): 26 people x $10.63/day x 3 days = $ 858
- Photocopies: 10 cents/copy x (20 sheets/questionnaire * 250 questionnaires + 21 people x 50 sheets of training materials + 10 copies of the KPC report x 75 pages + 12 QI Checklists x 5 days) = 10,980 copies x $0.10 = $1,098
- Data entry personnel: M&E Technicians, no charge. 2x100 +200 usd
- Data analysis by Director of Health Programs (no extra charge)
- Other travel costs, est.: 1241km * 3 cars* $0.45/KM = $1,675.50
- Traslation documents 20 paginas X 20 usd c/u 400 .

Total costs of KPC: $10,343.54

- **Local/National calls:** These are calls within Mozambique and to the U.S. office. We have budgeted for $100 in calls each month, based on past history. The project staff will rely on internet for most of its communications between Beira and Maputo, and Beira and the U.S. For most of its communication with each district, cell phones will be used, supplemented by use of the shortwave radios in government and MOH offices.
- **Behavior Box:** The behavior box is a card kept with the growth charts of infants, and used to record the behaviors of the mother (e.g., exclusive breastfeeding). The numbers needed are based on the infants in the program in each year of the program. The estimated cost for these is $0.05 cents each (bought in bulk). This price estimate is based on the cost of the stickers in other child survival projects. Based on 22,476 infants (0-23mths) in year 1; 11,238 new infants in year 2; 31,183 children 0-23mth in phase II districts plus 11,238 new infants in phase I districts for year 3; 32,449 new infants in phase I and phase II districts year 4; 32,449 new infants in phase I and phase II districts for year 5.
- **Oil, maintenance and insurance for motorcycles:** The cost for this is based on $50 per month per HPSO. Each HPSO will have motorcycle to carry out supervision and site visits. The cost for this was estimated based on current costs in FH's Title II health program.
- **Deworming medications:** Half of these will be paid for out of FH's cash match and the remaining half will come from the MOH (portion showed in the budget is cash match only). Costs are based on $0.04 per dose for children 12-59m of age.
- **Internet service and internet start up fee –** cost associated with CSP manager's satellite modem for improved communication with FH HQ and USAID/Maputo.
- **Electricity for Manga district office:** In Manga, funds are requested to pay for electricity at $100/month. (We will be sharing a building there.)
- **Maintenance of District Offices:** Funds are requested to pay for cleaner, water, and small items required for the maintenance of district offices at $50/month per office.

- **Router –** to share the CSP Manager's satellite internet connection with the field M&E program staff.
- **ADDITIONAL MATCH not shown in the budget includes Vitamin A supplements, a portion of deworming drugs, ORS packets, and growth monitoring cards which will be provided by the MOH.**

XIII. Other Direct Costs, HQ:

- **Phone International calls:** This includes phone charges for calls to Mozambique which are rare – three phone calls each year @ $65 each. (Normally Skype VOIP, Groove.net, and other software will be used for voice communication. This has proved successful in our other projects in Mozambique.)
- **Mozambican Visas:** FH requests funds to cover the two Mozambican visas used each year during visits by the Director of Health Programs (HQ backstop) to Mozambique. The cost for each visa is currently $25. This will be covered by USAID direct in year 1 and via Match in years 2-5.

XIV. Construction, Field –

- Some project areas do not have offices to rent and there we need to construct or rehabilitate buildings for this project. Land will be provided free by the government. In Manga, we will pay $11,200 for rehabilitation of a building. In Chemba and Maringue, we will be constructing small buildings. Funds are also included for construction of district offices in new Phase II districts. This will be paid with matching funds.

Total Direct Expenses – Total direct costs requested from AID to support the proposed CS project is **$2,201,585**. The portion of the overall budget covered as a **match is 25.3%.**

The total estimated **expenses for HQ** requested from USAID are **$179,233** representing **7.2%** of the total budget. Total field costs requested from USAID are **$2,022,352.**

Indirect Expense – The AID approved indirect rate for FH is currently **13.55%** based on our auditors recent single audit report. We have submitted this rate to USAID for approval. The total indirect costs requested to be covered by USAID are **$298,315.**

USAID Total – The total amount requested of AID to support this project is **$2,499,586**.

Cost per Beneficiary – Given that there we proposed to serve approximately **198,594** CS beneficiaries in Year Five, this represents a **cost per beneficiary of $2.52** of USAID funds per beneficiary per year. Recurrent expenses will decrease significantly in a district after the first 24 months of intensive education by Promoters and Leader Mothers. (See Sustainability section.)

F. Responses to DIP Reviewer Comments

Comments from WR:

1. What **selection criteria** were used **for Leader Mothers?**
   Lead Mothers are women aged 18-60 years of age, who have had at least one child, and are willing to volunteer for the program. The Community Development Committees recommended candidates from among all the eligible women, and Food for the Hungry interviewed and selected the Lead Mothers.

2. What **specific strategies are being examined to reach men** at household and *community levels knowing that household decisions are made largely by men? Based upon Food for the Hungry's previous experience with CG's in Mozambique, and subsequent reduction in child mortality (>60%) and malnutrition rates (42%), we feel confident in the impact made by working principally with groups comprised of women. Male decision makers will be involved in the Community Development Committees. Committees are composed of community leaders, teachers, TBA's, religious leaders, and other prominent community members. The committees were formed at the onset of the program and were instrumental during census and community mapping exercise. They also facilitated selection of Lead Mothers (LM's). During the life of the program, these committees will serve as the link between project communities, the MOH and FH. All program activities are approved by the committees prior to implementation. The committees also help supervise program promoters.*

3. **Deworming** – this is a major component of the nutrition intervention. The rationale for starting deworming from age >12months (versus <24m) is unclear, knowing the limited impact of deworming on growth before 24months?
   The MOH policy is to provide deworming medication to children <12 months of age and our program will therefore start at age >12 months versus 24 months.

4. FH might want to prioritize **strengthening the 'weaker' MOH facilities** in resuscitating and stabilizing children with severe malnutrition and then promptly referring them to Hearth programs.
   This program is focused on prevention and therefore measure to strengthened weaker MOH's facilities in the treatment of SA is outside of the scope of this program. However our Title II program will be training health staff on WHO guidelines for the Management of Severe Malnutrition and encouraging them to replicate the training with MOH. We also envision assessing MOH staff's current knowledge and skills in that area, and offer trainings where trainings are needed.

Comments from FANTA:

1. The DIP does not **define severe malnutrition**, and only refers to the indicator weight for age (underweight) that is used to identify children for PD/Hearth. Is severe underweight being used as the referral indicator for therapeutic feeding?

FH/Moz will be using bilateral pitting edema as the indicator for SAM, all children with bilateral pitting edema will be referred to a health facility. We will also be checking for visible wasting – i.e buttocks for saggy skin – and measuring MUAC.

2. **How often will screening be done** – just every 6 months with PD/Hearth screenings or will GM/P sessions refer children as well?
Hearth screening will be conducted every six months. We will not rely on MOH GM/P data for Hearth referral but rather we will weight children 6-59 months of age every six months, and check for bilateral pitting edema to identify SAM children. As we can not assure the quality of information collected during GM/P, and this data charts boys and girls on the same curve as opposed to gender specific growth curves, we will rely on the data collected during semi-annual screenings for enrollment into Hearth.

3. FH might consider **referring all SAM cases**, and then enrolling mothers and children in PD/Hearth after they have finished therapeutic care to encourage necessary behavior change and prevent further malnutrition.
Based on FANTA's very helpful suggestions, FH will enroll severely underweight children (<-3 Z-scores) without complications into our PD/Hearth program. All children with SAM will be referred to therapeutic feeding centers. Since the submission of the DIP, the MOH has subsequently refused CUAMM's CTC feeding program and therefore all SAM children will be referred to therapeutic feeding centers.

4. **Capacity Building of MoH**. What are CUAMM and FH's plans to help the government improve their nutritional rehabilitation program? The DIP mentions that the FH Title II program will allow access to state of the art training on management of severe malnutrition. How does this complement the CUAMM work? Can this expertise be used to help the MoH improve their treatment of severe acute malnutrition?

During FH/Moz previous experience with the CG module, without further inputs into the MOH health system, a demonstrative reductions in child mortality (<60%) and malnutrition (42%) resulted. It is our firm believe that the expansion of this program during our CSHGP will greatly impact both malnutrition and mortality rates. While the MOH is a prime partner in this program and will fully participate in all program trainings, a specific health facility component is outside the realm of this program.

Our Title II program is in the process of developing a training manual for clinical staff for the Management of Severe Malnutrition which will address health facility quality.

CUAMM currently supports feeding centers in the Beira Health District Hospital and in the malnutrition ward of Beira Central Hospital. They are also collaborating with the Catholic University of Medicine in Beira to provide lessons and support to medical students, to provide general support of for the health districts of Beira and

Dondo (includes public health programs and support to MCH services), as well as a program supporting the pediatric ward and the pediatric HIV day hospital and laboratory of the Beira hospital.

5. **PD/Hearth.** *Please see response to question 2 above as well. Following the successful model used in our Title II program, we will conduct Hearth screenings every six months. While Hearth will occur ever six months in each community, recipes covered during Hearth sessions will be integrated into the Care Group teaching modules. All moderately (WAZ <-2) and severely underweight children without complications (WAZ <-3) will be enrolled in Hearth.*

6. **Exclusive Breastfeeding recommendations.** *Both the MOH and this program's exclusive breastfeeding indicator is EBF for children under six months. Any mention of 3 months in the DIP was in error.*

7. **BCC Messages Nutrition Section**. It would be helpful to use The Guiding Principles for Complementary Feeding of the Breastfed Child and Guiding Principles for Feeding Non-breastfed Children 6-24 months of age as a basis for your nutrition messages
In addition to other resources, FH will use the Guiding Principles when developing nutritional modules/messages. We will also be trying to get a copy of the WHO IYCF guidelines and use that in the development of our CG modules.

8. **Maternal Health and Nutrition.** Although reducing morbidity and mortality of pregnant women is listed as a goal, there is no description of a specific intervention to improve women's health and nutrition, aside from a short mention in the training guide. There are no indicators for maternal health either. Could FH provide more information as to what they intend to do to address maternal health?
In addition to the maternal nutrition module, based upon the MOH request, FH/Moz will be providing post partum iron supplements and can add an iron indicator. Leader Mothers will also promote antenatal care and birth preparedness, and use educational messages to assure that all mothers know danger signs during pregnancy and delivery. FH is also preparing a proposal for submission to the Flexible Fund to obtain funds to add promotion of the Standard Days Method and other family planning methods via our Care Group Structure in Mozambique.

9. **M&E - Nutrient-dense foods indicator***:* adding oil to a food would make it an energy-dense food, but not necessarily a nutrient dense food. In fact, oil can reduce the nutrient density of foods. This indicator measures energy density.
We will be promoting the use of both energy-dense and nutrient-dense foods, but our indicator will be modified to read "energy dense."

10. **Trainer's guide –** *the guide included in the DIP was a draft from our Title II program and is a work in progress. The final modules for this CS program will focus on the modules outlined in the training plan.*

Comments from CSTS:

1. Do I understand correctly that the plan is that the **public health nurse essentially will replace the supervisory function** of the project-paid promoter after project period?
That is our goal. In some cases, it may be other health post staff. Also, it may be necessary to have LMs come in to the health post for education some months, and in other months, have the health worker come to the community.

2. It is excellent to see that there has been work to get buy-in to achieve integration of community-based data collected through CG into the MOH HIS. How about **births registered** this way as well? Is this being done but just was not mentioned?
Since the submissions of the DIP, we have had to re-evaluate the level of detail contained in our community level HIS – specifically the CG Registries – to more accurately reflect field realities. As the literacy rate is extremely low in our program communities, we will rely more on verbal vital events reporting from our LM's to their program Promoters. This program is working closely with WR's successful CG program in Mozambique in producing similar data collection tools to have a unified HIS reporting system to the MOH. The vital events reported by LM's will include deaths and births and this information will be forwarded to the district MOH offices. FH will now conduct quarterly monitoring surveys (mini-KPC's) to get more detailed information not collected during vital events reporting by LMs.

3. The one thing that seems a bit sparse in the **M&E plan is the data on Objective 4**, although perhaps some key indicators are planned to be tracked but are not written here. It would be good just to see simple things tracked like % scheduled HH visited by LM, % CG member attendance at biweekly meetings, average pre-/post-test scores on modules, % scheduled supervisory visits by promoters, % quarterly supervision visits by MOH public health nurses, % population covered by CG (presumably 100%), and % annual retention of CG members during and after intensive supervision stage.
In the past, USAID has asked us to keep our indicators to a very concise set, and so we have not included some indicators in our results framework that we will be tracking internally. We will be tracking most of these things through the HIS. If USAID would like us to report these indicators, as well, we would be glad to do so.

4. Are you, in fact taking this percentage (16.8%)? If so, what is the source? If I look at the **US Census Bureau site** (http://www.census.gov/ipc/www/idbsum.html) and look at Mozambique's current population pyramid, then the fraction of population represented by 0-59 month olds is 15.2% (2,958,000 / 19,407,000).
We took data from this page from the US Census Bureau: http://www.census.gov/cgi-bin/ipc/idbagg and divided the number of all children 0-59m (2,985,749) by the total population (17,768,457) which gives 16.8%. The page that you site is more up-to-date (2005 mid-year vs. 2000), but we were unaware of this page at the time of the proposal and DIP. We would like to add in mothers of children 0-23m of age which were not included in our beneficiary table originally. Given that we will be giving some attention to the nutrition of all women, not just pregnant women, we feel that we

should add them to our beneficiaries, as well. This will more than compensate for the over-reporting of children based on the 16.8% vs. 15.2% difference.

Second, you should be explicit (if you are doing this) that you are projecting your ***end of project*** **number of U5 beneficiaries**. There is nothing necessarily wrong with doing this, but it should just be made explicit as many other project use beginning of project numbers.
We based these counts based on previous feedback from USAID on how to count beneficiaries in a child survival project (e.g., during the FOCAS/Curamericas Child Survival Project). We are basing our beneficiary counts on Year 5 counts. In reality, we will reach more than just these children since we will reach infants born each year.

5. **The child mortality numbers on pg. 22** – I have a minor point: While it is nice to make the numbers "concrete" they don't add up. That is, if U5MR is 205 /1,000, then with 715,000 annual births, 146,575 would die before age 5 (not 128,000 as the sum of the disaggregated numbers seems to imply).

   This sentence is straight from a UNICEF website, but we agree that the statistic is wrong. (http://www.unicef.org/mozambique/child_survival.html)

6. **Why it is that you decided to limit the intervention** areas to malnutrition and diarrhea and not address two of the project area's greatest causes of U5MR (i.e. malaria and pneumonia).
   If we added on more interventions, we would have had to keep all Promoters in the first area for longer (which would have hindered scale-up); or (2) spend less time on health promotion around each intervention (which may have hindered impact). You said, "will be missing about ½ of mortality by excluding malaria and pneumonia." Since malnutrition overlies 40% of all deaths, if we halve malnutrition, we should be able to decrease malaria and pneumonia deaths, as well, at least to some degree. ***We will, however, be seeking additional funds to add on other interventions, especially malaria (through the PMI in a year or two) and family planning (through the Flexible Fund this year).*** *We will be covering care seeking for pneumonia when we talk about danger signs and as Leader Mothers are trained in IMCI.*

7. What will be **the value added of the CS project in these districts with Title II coverage?**
   We will not overlap with the communities that have Title II Care Groups, so the CS project will not be active in the portions of those districts where the Title II Care Groups are operational.

8. **GM/P questions:**
   We did not know that there was 70% coverage by facility-based GM/P at the point of writing the proposal. The plan is to have more and more mothers going to health facilities for GM/P and to receive increased/improved nutritional counseling at the community level. We will be recommending that the MOH use the Behavior Box at

the health facility level, as well, but we first need a chance to educate them on the usefulness of paying attention to and tracking mothers' behaviors. If the experience shows that the MOH has reached a plateau of GM/P even with the increased promotion, we hope to use that to convince the MOH that some GM/P needs to be happening at the community level. We feel that some of these issues will be easier to resolve once we have been working together with the MOH for longer and have developed more trust and camaraderie.

9. **How will non-economic and non-access barriers to care be addressed?** Won't MOH be the entity that maintains CG (at least in part) and the "health of the health care system" will therefore impact the chance for sustainability.
We do not think of the MOH representatives as the chief actors to maintain the Care Group structure and community-level health promotion. The chief actors will be the Leader Mothers themselves, with some support from the MOH. Once we have empowered the Leader Mothers to take more control over the health of the women and children in their communities, we want them to begin having more of a say in terms of what is happening in the health facilities, how they are treated, etc. In this initial phase, we want to work with the MOH (e.g., during supervision visits) to further the idea that the MOH should seek out the opinions of Care Group members as a source of information for where they need to make HF improvements. We expect this to be a long and sometimes arduous process since there appears to be very few incentives in place for MOH health facility workers to be responsive to community needs. It may require structural change in the MOH. Also, we need to be careful about how we approach this since we do not want to jeopardize the relationships with the MOH by encouraging Leader Mothers to push from the bottom up for rapid changes in health facilities.

10. **The initial KPC was not translated to Sena**.
We agree that it would have been ideal to have the KPC questionnaire in Sena. We pushed for that during the KPC training process. We found, however, that, while the KPC interviewing teams had Sena speakers, they had very few Sena readers. For this reason, we had to rely on verbal translations. For the Mini-KPC, we will need to come up with a creative solution to this. One possible solution may be to give interviewers a tape that which they can review that has the official Sena that should be used for each question. They can practice repeating the questions using the same wording as the tape to ensure that the same questions are used.

Comments from USAID mission:

1. One or more **performance indicators** on maternal health similar to that in USAID Strategic Objective 8 (SO8) will balance the performance monitoring process.
As mentioned above we will add an Iron indicator.

2. Strategic inclusion of interventions like: family planning & child spacing linkages with PMTCT, prevention of early pregnancies, emphasis on maternal nutrition during pregnancy, and support to provision of barrier family planning methods to prevent re-

infection with STI/HIV and child birth preparation could significantly impact maternal and neonatal/child morbidity and mortality.
We are unable to add on additional interventions without more funding given that we are undertaking a large scale-up of the model. However, as stated above we plan to submit a proposal to the Flex Fund to promote the Standard Days Method and other FP methods (including barrier methods) in the project communities. Maternal Nutrition during pregnancy will be given more emphasis in the Care Group modules. If we find additional sources of funds, we hope to piggy-back other activities. For example, we have talked to LaRue Seims at Save the Children about the possibility of getting money from SCF for Operations Research on activities for neonatal mortality reduction, and we hope to eventually secure PMI funds to add on a malaria intervention on the Care Group structure. Once it is in place, it would be very cost-effective to add on interventions.

3. **Impact indicators not only process indicators** of each goal could further clarify achievements of expected results.
We do plan to measure three impact-level changes – (1) changes in the proportion of children underweight, (2) changes in the diarrheal prevalence rate (through mini KPCs so that we can see what is a true decrease and what is seasonal variance), and (3) some less-rigorous measurement of under-five deaths.

4. Nutrition: **Post partum vitamin A** supplementation which is being implemented nation wide was not explicitly mentioned.
We will definitely be supplying postpartum Vitamin A. It was an oversight that this was not explicated stated in the DIP.

5. **Birth weight monitoring at community** level could significantly impact on future nutrition and morbidity outcomes of babes and enhance BCC.
We do not have a means to measure birth weights within 24 hours of delivery, and cannot do that without extensive involvement and training of TBAs, something which is not within the scope of this project.

6. The use of sodium hypochlorite solution **"Certeza" water purifier** presently being distributed by PSI in the country could further improve the quality of water in targeted districts; pending adoption of a new strategy on the use of zinc for the treatment of diarrhea by the MOH.
FH has begun forging a partnership with PSI in Sofala province and will be promoting the use of Certeza for water purification. PSI will conduct trainings on the use of Certeza and will provide program promoters and LM's with Certeza.

7. The use of **bicycle ambulances** or community managed transportation to transfer sick children and pregnant women from communities to health facilities has been shown to improve access to health services and reduce mortality in Mozambique.
We are unable to afford the bicycle ambulances, and have heard that they were not working that well in other areas of Sofala. In our Title II project, we saw significant reductions in mortality (62%) without improving transportation. If the mission knows

of where we can get funds for these, we could pilot them in a district.

8. **Gender** – It seems this project is gender bias in favor of females who are socio-culturally weak in decision making in targeted districts ; is there any reason why only leader mothers are considered? The draft MOH strategy on community participation in health through Community Leaders councils could balance the gender issue raised.
   We are using the equivalent of Community Leader Councils, via our Community Development Committees, in addition to the Care Groups. Please see response to WR's comment #2 above. FH is implementing the same model which has already shown great success in changing health practices and impact.

9. **Minor adjustments in relevant areas to Annual work plans**, in conformity with Provincial health priorities and strategic plans could further strengthen the relationship between the project implementers and Government partners.
   We will definitely coordinate with the MOH and make adjustments where necessary.

ANNEX 1: RESPONSE TO APPLICATION DEBRIEFING

Executive Summary weaknesses:
This section would be further strengthened with a clear summary of the Care Group Model up front, since it is the central element of the whole program, which would then be expanded in this section and in the Program Strategy.

The executive summary should name all of the principal authors of the application.

RESPONSE:
The DIP clearly outlines the Care Group Model in the executive summary and names the principal authors of the DIP.

Description of the PVO Applicant weaknesses:
In comparison to their previous work, FH is proposing a target population of practically twice as many beneficiaries with only a 60% increase in the number of Leader Mothers.

RESPONSE:
One of the primary goals of this program is to transfer the knowledge, skills, tools and passion needed for effective and sustainable community health development through the Care Group model to project partners in order to continue child survival activities once the project has ended. In order to facilitate taking this model to scale, and convincing the MOH of its efficiency, we made some adjustments to the model to in turn reduce the cost-per-beneficiary. Leader Mothers will not have to visit as many households – twelve as opposed to the original 14 – and to compensate we will have 14 Leader Mothers (as opposed to 12) meet in each Care Group. To reduce the amount of traveling required of our Promoters, we have decided to employ 64% more Promoters. FH will employ 30 Promoters in Phase I of the program and in Phase II an additional 39 Promoters will be hired. Each Promoter is responsible for supervising 5 Care Groups. Therefore with a total of 69 Promoters, and 375 Care Groups, the program will reach a total of 57,960 households.

Situational Analysis weaknesses
This section would be strengthened with a stronger case of the need for the selection of the two provinces, going beyond the MOH request. Some of the rational provided seems to raise more questions than answers. For example, Zambezia was identified as having the severest diarrhea rates in the country, yet 76% of mothers in Zambezia, as opposed to 45% of mothers in Sofala, know about ORS. Ensure that data is consistently presented in ways which reflect its relevance in the context of the country's statistics.

Provide a more in-depth discussion concerning existing health center, health posts, and hospitals, covering issues of access and quality of service. Include an explanation as to how FH identified the barriers to accessing care.

Include more description of food availability and access in this population and how these elements of food security have been effectively addressed.

Even with the space constraints, provide some discussion of family planning, recognizing the delayed childbirth and child spacing are key determinants of maternal and child nutrition and health status.

Include a better definition of the links with PEPFAR and exactly what program would be impacted and in what ways.

Clarify how the cost in USAID funds per beneficiary was calculated.

RESPONSE

Since the original proposal was submitted, Food for the Hungry has re-evaluated the location of districts in which the expanded impact program will be implemented. Please refer to section D of the DIP which outlines in detail the rationale for focusing program activities in Sofala province.

Please refer to section E.1.e of the DIP regarding existing health infrastructure and both access and barriers to health services.

Food availability: Sofala province, with a total population over 1.62 million (over 1.1 million rural population), is one of the most food insecure provinces in Mozambique. Farming families in Sofala remain chronically food insecure despite the rich and abundant agricultural land, a situation exacerbated by chronic droughts, floods and pest outbreaks, reducing their ability to produce food for their own consumption and for market. This situation is further complicated by the rapid spread of the HIV/AIDS pandemic which affects an estimated 26% of inhabitants in Sofala. In 2005/06[33] out of 587,500 people affected by drought (January-March 2006 estimate of affected people), 14% are in Sofala (ranking 4th among the seven most affected provinces).

Food is more available right after harvest and stocks decline thereafter. Livestock production, especially chicken, is periodically affected by disease outbreaks. Numbers of other small animals such as goats has been reducing due to increased sales to be able to cope up to increasing vulnerabilities. Food insecurity is particularly wide spread among the most vulnerable households and communities. To improve the food security if the population of Sofala, Food for the Hungry has implemented a Title II Food Security program targeting 28,080 households in Caia, Marromeu, Namatanda and Gorongosa. This program, which will end in Sept 2006, focuses on increasing per capita income of

[33] According to Food and Crop Assessment Report of June 2005 by FAO and WFP Mission

farming families and decreasing chronic malnutrition in children 6-59 months of age. The health and nutrition interventions of this program were carried out via the Care Group model. The effectiveness of this program is evident in the 40% (from 50.4% to 30.3%, $p<0.05$) decrease in malnutrition found from 1998 to 2001, with concomitant, dramatic changes in mothers' nutritional and other health practices.[34] Based on midterm evaluation and recent vulnerability assessment recommendations, FH has submitted a proposal for a one year extension of this program. During the extension period, priority will be placed on interventions that diversify livelihood options and enhance coping abilities ultimately leading to reduced food insecurity. The complementary interventions fit into the DAP strategic objectives of increasing household income and reducing of malnutrition.

Family Planning: Program activities will focus on interventions for nutrition and diarrhea, integrated through the household and community IMCI strategy. To add additional intervention strategies would prevent FH from maintaining the current cost per beneficiary. Therefore while FH recognizes that delayed childbirth and child spacing are key determinants of maternal and child nutrition and health status, family planning activities are outside of the scope of this expanded impact program.

Links with PEPFAR: please see section E.1.g of the DIP for further information regarding the linkages with the PEPFAR funded ABY program.

Cost per Beneficiary: The annual cost per beneficiary was calculated by taking the total USAID budget of $2,499,910 divided by the total number of beneficiaries 155,667 divided by the number of years (5) of the program: $2,499,910/155,667/5 = **$3.21 per beneficiary per year.**

Program Strategy and Interventions weaknesses:

This section would be strengthened with a reduction in redundancy and further fleshing out of technical aspects.

It would have been useful and appropriate to have the program objectives included here in the text. Reader are instructed to refer to the next section to learn of the program objected and then are referred again to an Annex.

Provide further discussion on ameliorating issues relating to transportation, beyond heaving leading mothers in isolated areas.

FH is encouraged to make zinc universally available and used as quickly as possible, dispensing with extensive evaluation, etc. MOST has developed programmatic guidelines. Dispersible zinc tablets can be procured directly from Nutriset in France. CSHGP can help with the waiver.

Early childhood care is going to be largely determined by the mother's health, which warrants a discussion of maternal health issues. Maternal anemia is a huge issue that has

34 Berhane, Y & Tesfaye F. (Sept. 2001). Food for the Hungry International / Mozambique Health/Nutrition Program Final Evaluation Report.

effects on birth outcomes (maternal and prenatal mortality, birth weight, development) and subsequently on the mother's health. Document if women are getting adequate iodine, and the local accessibility/affordability of iodized salt. FH should consider the opportunity to ensure that women are getting iron/folic acid supplement in the antenatal and postnatal period, malaria prevention and treatment, antihelminthics, and potentially iodized oil supplements during antenatal care according to WHO recommendations. The structures are in place to add this.

Ensure that mother do not receive a high-dose vitamin A supplement beyond 8 weeks postpartum, as it can be teratogenic in early pregnancy.

Within such a food insecure context, this section would be strengthened with more discussion on availability/access to local food and vitamin A, ensuring that children over two do not fall through the gaps. Discuss where added oil and vitamin A rich foods would come from, going beyond the existence of Care Groups.

With Hearth workshops every 6 months, children could wait as long as 5-6 months to get into a Hearth program. Rather than being restricted by the HEARTH methodology and keeping it walled-off from the CG IYCF/CMP activities, consider incorporating the principles of Hearth within the CG bi-weekly/monthly counseling sessions to address the special needs of these malnourished children (of benefit to all mothers).

The severely malnourish will be referred to facilities despite evidence that the community-based therapeutic care (CTC) model using ready-to-use therapeutic food (RUTF) may be a better option which could perhaps be introduced on a pilot basis.

Provide additional information on time allocation requirements from Promoter and Leader Mothers, compensation, and how these may or may not present constraints/challenges for long-term sustainability. Include in the discussion the turnover for these positions, and any retention problems.

Describe how key inputs for Care Group use are procured, e.g. ORS, vaccinations, antihelminthics, antibiotics, chlorine.

Include a time/phasing-in table for scale up to provide greater clarity.

RESPONSE

Please see Program Description – section E.3 for detailed information and elaboration regarding the program strategy.

Concerning ameliorating issues regarding transportation:

One of the major strengths of the Care Group model is that it provides health education via home visits, therefore addressing a primary barrier in the exiting MOH system - the lack of a mechanism to do large-scale health promotion due to the non-existence of CHWs.

By having LMs visit *every* caregiver of children under two, equity for health and nutrition education will be ensured. A mechanism for addressing transportation to and from MOH health centers is outside of the scope of this project.

Zinc: FH hopes to provide zinc supplements to children with diarrhea but is awaiting (a) MOH approval for the use of Zinc in Mozambique and (b) additional funding and/or GIK to cover the cost of zinc packets. FH has been in discussion with SCF and Johns Hopkins regarding the quantities of zinc necessary for this program.

Maternal Care:
During Model #7 FH will provide lessons regarding maternal care and nutrition. Some of the topics included during these lessons are: nutrition during pregnancy, iodine-rich foods (marine products)/salt and other important nutrients, iron supplements, Vit A, importance of prenatal care and VCT, and PTMTC.

In addition to nutritional education message, Leader Mothers will be tracking maternal care via the Care Group registers. These registers (please see example of maternal pages in Annex 13) will collect data concerning their antenatal visits as well as iron supplements received during pregnancy and breastfeeding. Leader Mothers will use these registers to track "defaulters" and tailor health messages to each mother. FH will refer all pregnant women to MOH health facilities for prenatal exams including iron supplement and malaria prophylactics. The MOH has large quantities of Iron supplements and does not experience stock out. During home visits with pregnant women, Leader Mothers will educate mothers regarding the need for pre-natal visit and need for early treatment of malaria during pregnancy.

FH has discussed the availability of **iodize salt** with the MOH. We were informed that iodized salt is readily available in urban locations but the MOH is not sure if rural communities are using iodized salt. They reported that goiter is not a large problem in Sofala. FH has tried, unsuccessfully to locate a report on Iodine through the MOH. We will continue to include the importance of consuming marine products and other important nutrients during our maternal care modules.

It has always been the plan of FH to include the principles of **Hearth** during bi-weekly Care Group trainings.

FH is working with the MOH in securing approval to deworm pregnant women participating in program activities. The current MOH policy is, during prenatal visits, to deworm all pregnant women in their 2nd and 3rd trimester.

Food security: a detailed discussion of food availability and FH's Title II program is discussed in the preceding section. FH will be providing Vitamin A supplements to children aged 0-59 months during Hearth screenings. FH's current Title II program promotes the use of community gardens for the production of Vitamin A rich foods.

CTC: FH will be partnering with CUAMM in the district of Manga. CUAMM currently operated a feeding center in Beira and will all begin CTC using plumpy nut. FH will refer severely malnourished children in Manga to CUAMM's programs. For more details regarding the partnership with CUAMM please refer to section 3 of the DIP.

Program Promoters are full time paid staff of FH who will dedicate 40 hours per week to the program. It is estimated that Leader Mothers will spend about two hours ever other week participating in Care Group meetings. In addition to the Care Group meetings, LM's will conduct home visits to the 12 beneficiary mothers they serve therefore devotion on average 8 hours a week to this program. **Sustainability** will rely heavily on the continuation of the Care Groups themselves, and studies in Mozambique have shown that Care Groups continue to meet and do health promotion long after project funding has ended. Studies conducted by World Relief in Gaza province found that of the 1457 volunteers active at the end of a Care Group project, 1361 (93%) were active twenty months later. Of the original number, 92 LMs had left their post or moved out of the area and 44 had died. Out of these 132 vacant roles, the communities had selected 40 replacements, and other volunteers trained their new colleagues and entrusted them with the educational materials of their predecessors. Furthermore, the changes brought about in the original program – similar to FH's dramatic changes with its Title II Care Group project – were maintained during this period, as well. A full thirty months after the end of the project, final program goals on eight key indicators continued to be exceeded. While FH has not yet pulled out of the communities in Sofala where Care Groups have been established (using Title II funds), FH has have seen the same low turnover rate and exceptional impact and changes in results-level indicators that are associated with a successful, community-supported project.

The MOH will provide FH will ORS packets, deworming medication, and Vitamin A supplements for distribution by program Promoters and Leader Mothers. The Swiss NGO Sight and Life will also supply Vitamin A if MOH stocks are not sufficient for program needs.

A time in/phase in work plan can be found in section 8 of the DIP.

Performance Monitoring and Evaluation weaknesses:

Include a discussion/identification here of the M&E expertise to be attached to the project in Mozambique, expanding on the reference in the Management Plan. Provide justification for why this position is only 25% LOE for M&E activities.

Include further discussion on the strength and/or weaknesses of the MoH system as well as how the two systems might be integrated.

FH will need to add an indicator for zinc.

The exclusive breastfeeding indicator should be for six months, rather than 9 months.

RESPONSE

Both HF HQ technical backstops – Lauren Erickson-Mamane, MPH and Tom Davis, MPH will provide a significant amount of M&E support to the field staff in Mozambique. Mr. Davis has worked with the CORE Monitoring and Evaluation Working Group, and was the lead author of the CSTS/CORE KPC 2000 Curricula and the FAM Title II Monitoring Toolkit.[35] Ms. Erickson-Mamane has conducted trainings in KPC Methods, LQAS, and QIVCL. She is currently a member of CORE's M&E working group. FH's technical team members have been leaders in the CS community in monitoring and evaluation of CS and Title II programs, have published manuals for USAID on monitoring and evaluation, and will transfer these skills to the partners in Mozambique during this project. Tesfaye Legesse will serve as the M&E Specialist in Mozambique and devote 13% of his time to this project. Derrick Capurana will serve as the M&E Technician for this program and devote 80% of his time to the project. Mr. Capurana and has been part of the FH/Mozambique M&E team for the past three years and is experienced with KPC surveys, monitoring and evaluating health and nutrition programs, data analysis, survey report writing, and training of staff.

The **Sofala provincial MOH** collects information regarding clinical services as part of the Sofala MOH monitoring system but does not collect community level data regarding nutrition and diarrhea. Currently the MOH monitors the number of children weighed, vitamin A supplements distributed, vaccines given and types of illnesses presented at health facilities. Both district and provincial MOH representatives have stated that there is no means of verifying the quality of this data. For the past year the MOH has been attempting to develop a system of evaluating data quality but to date do not have such a system in place. FH will provide training to district MOH representative on quality improvement checklists to facilitate monitoring and evaluating data quality.

FH is also developing various forms and M&E tools, such as Care Group registries and vital events reporting, that they will train both program and MOH staff to use throughout the life of the program. MOH staff will work closely with program staff in the supervision of Promoters and Care Groups and will serve as members of the CS Coordination Team during to monitoring all aspect of program implementation. Throughout the life of the program, FH will supply District, Provincial, and National MOH offices with copies of M&E and program reports.

Zinc supplementation has not yet been approved by the MOH. FH has discussed the potentiality of distributing Zinc supplements (only if addition funding for this activity is identified) and has been informed that UNICEF is in the process of developing a Zinc protocol with the MOH. Until such time that a MOH Zinc policy is in place, no supplementation will occur. When the MOH approves supplementation, FH will add an indicator for Zinc.

---

35 The Title II Monitoring Toolkit (Tom Davis, MPH and Julie Mobley, MSPH, authors) is available through Food Aid Management (FAM). See http://gme.fhi.net/fse/isapr/index.htm#mneToolKit or http://www.foodaid.org/worddocs/moneval/toolkit/FAMTIIMonitoringToolkit.ZIP.

The breastfeeding indicator was an error and has been subsequently corrected to 0-5 months.

Management Plan weaknesses:
This section would be strengthened with one organizational chart which clearly delineates the roles and responsibilities of both HQ and the field as an integrated whole.

Include further discussion on the practical issues surrounding the creative idea of having the some of the creative idea of having the some of the coordination facilitate through a virtual classroom.

The management and human resources table need to be strengthen to more clearly indicate FH's plans. It needs to include a discussion on the roles and responsibilities of FH staff as well as partner staff. Indicate how many M&E technicians are attached to the project. Better illustrate the LOE of partners. Better illustrate the LOE of partners.

The work plan would be improved buy using a delineated time/phase/year/quarter table, which would make it easier to visualize how the activities flow. As a suggestion, identify the main sand sub-project activities in the left hand column with recognition given in the following columns as to when these activities would take place.

FH may want to consider OR on the recurrent inputs to keep the Care Groups going effectively.

RESPONSE
Annex 5 of the DIP includes a unified organizational chart for both HQ and field staff involved in the expanded impact program.

FH has had excellent experience using Groove and Elluminate during the implementation of our PEPFAR program. Elluminate virtual classroom software allows program partners to record meetings so that those who miss a meeting can listen to the record afterward to get up-to-date regarding program activities. Furthermore it allows partners from different areas of the country, as well as different countries all together, to share documents and conduct live meetings. FH has also had tremendous success using Groove for sharing documents across partners and countries. While both Groove and Elluminate help communications tremendously, it is necessary to have multiple means possible to assure steady communications (e.g., Groove, Elluminate, Skype, e-mail, phone, and fax).

Please see section 5 of the DIP – Program Management for additional information regarding the roles and responsibilities of project staff. The roles of partners is outlined in section E.3 Program Description.

A time in/phase in work plan is presented in section 8 of the DIP.

FH will be working with Mozambican universities and other partners to conduct OR on the effectiveness of the Care Group Model. Please see section 4 for more information regarding operational research.

Collaboration with USAID Field Missions weaknesses:
None identified

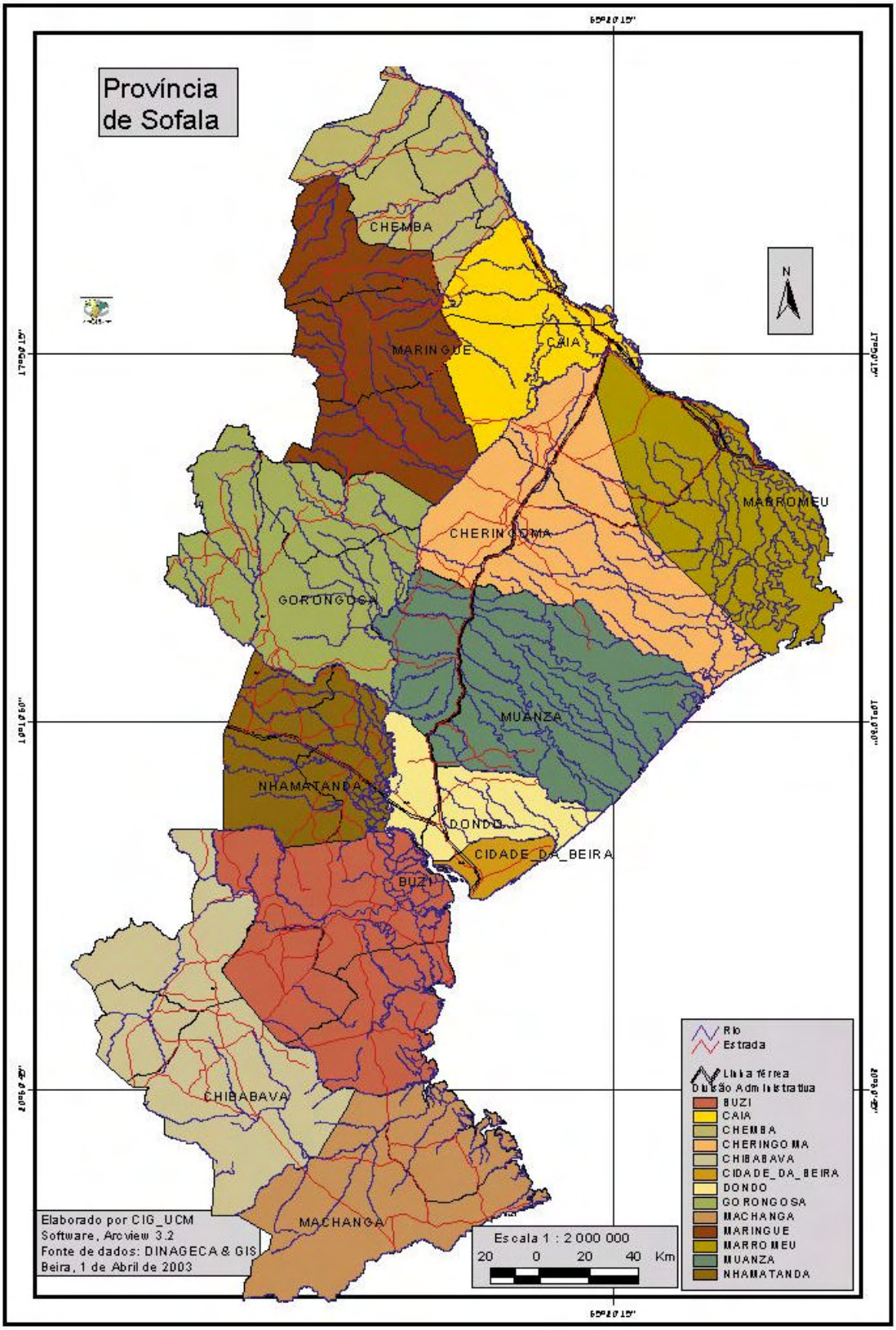
Overview Comments
Although there is difficulty finding qualified Mozambican staff, FH is encourage to include more Mozambican staff in key positions.

In order to ensure sustainability of this program, DH should ensure more MoH involvement in implementation, especially on the behavior change communication component.

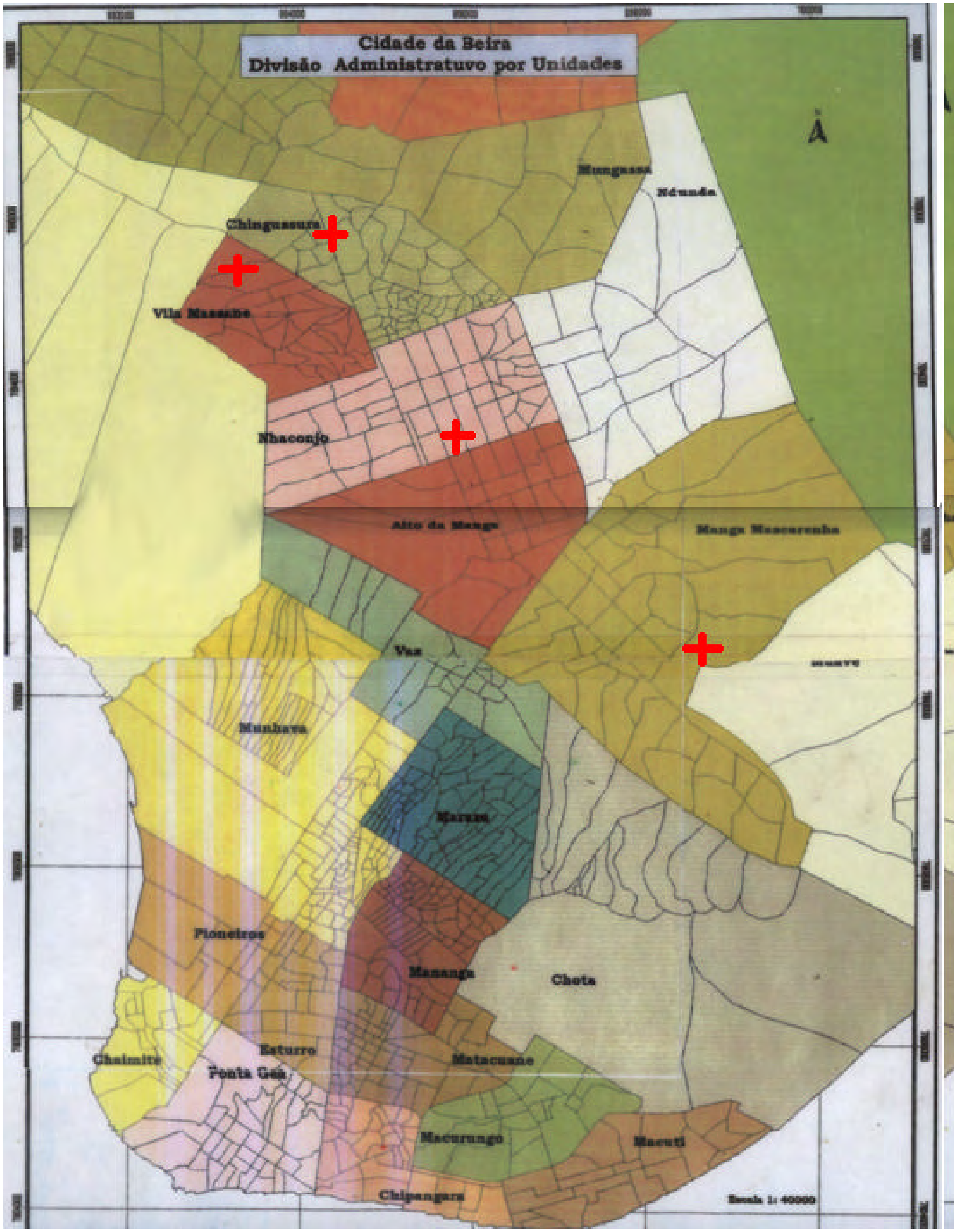
RESPONSE:
Due to the long civil war and lack of education during that period, it is still difficult to find qualified candidates for the highest positions. However currently 98% percent of the program's paid field staff are host country nationals. Furthermore Mozambican staff plays the most crucial role in this program – that of our Leader Mothers. .

For more detailed information regarding the role of the MOH please see section 3 of the DIP.

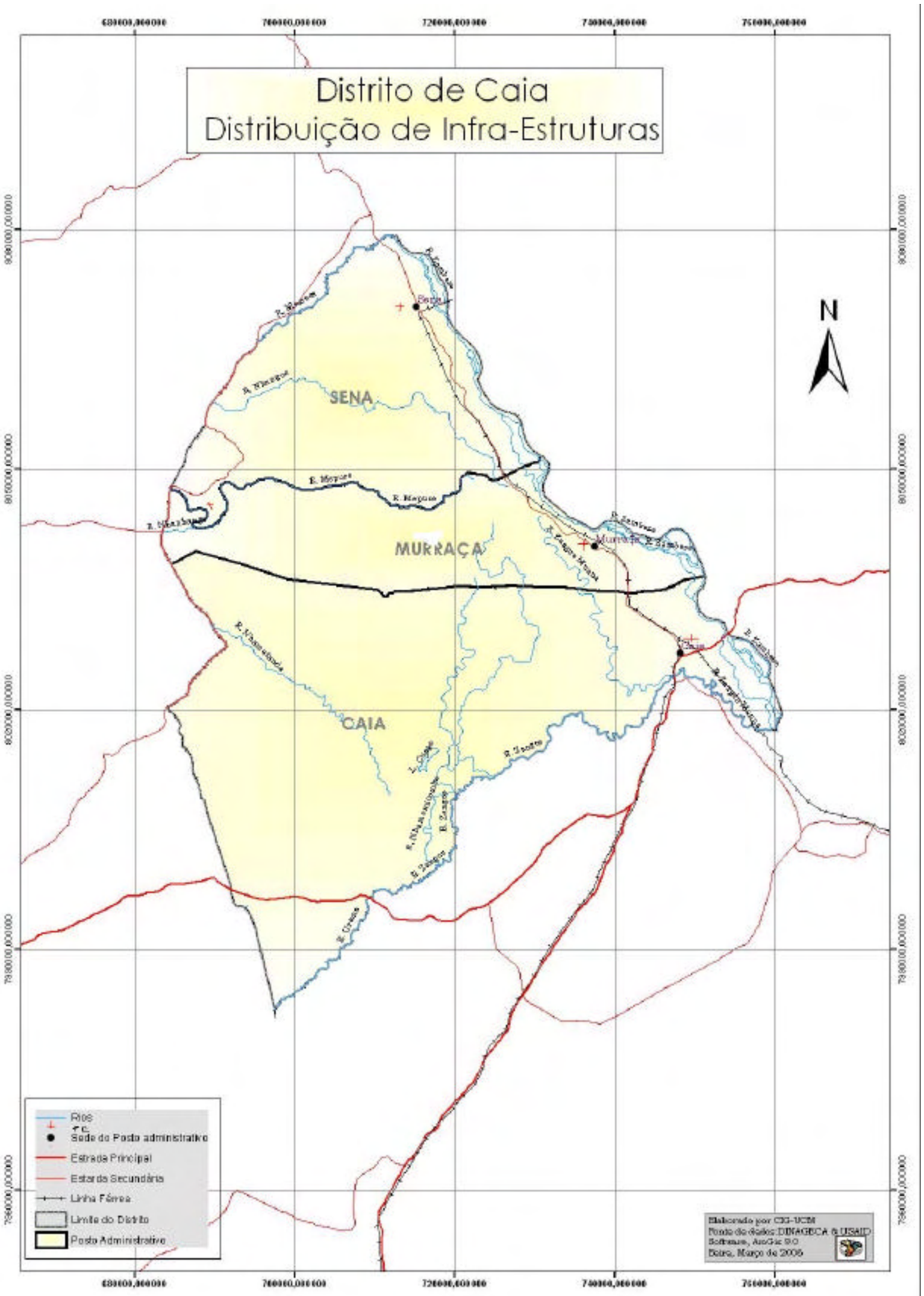
ANNEX 2: Maps of Project Area

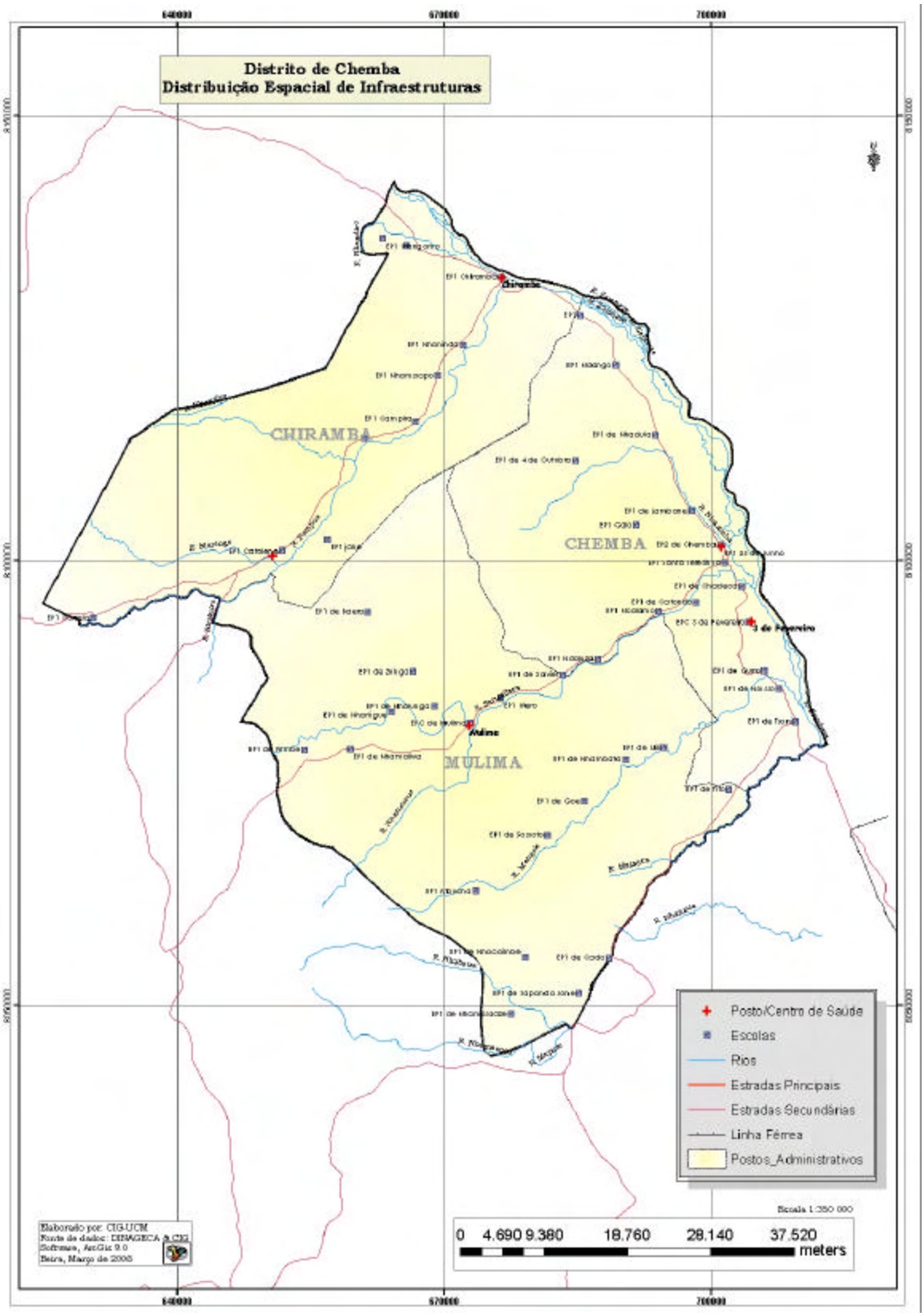


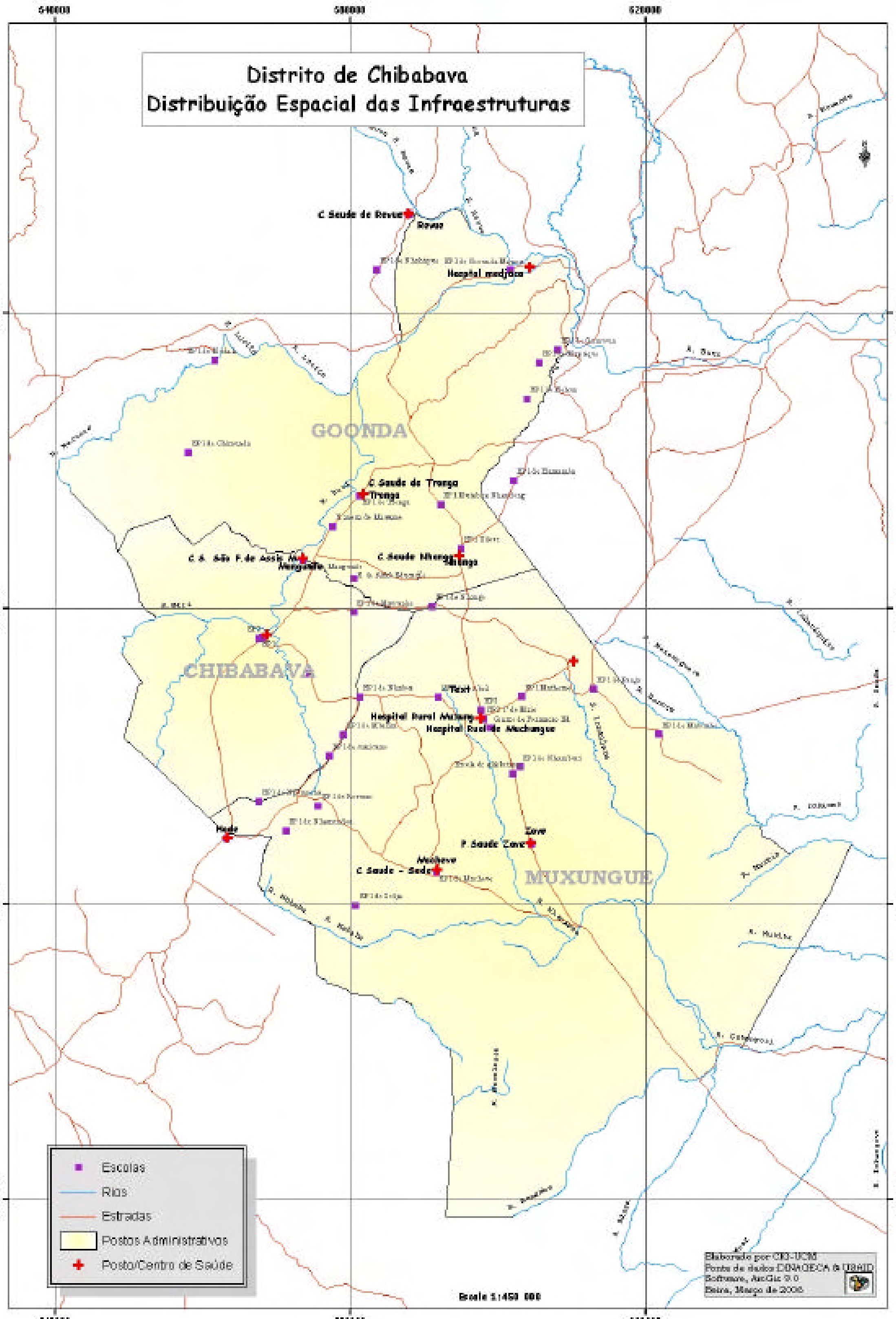
Beira

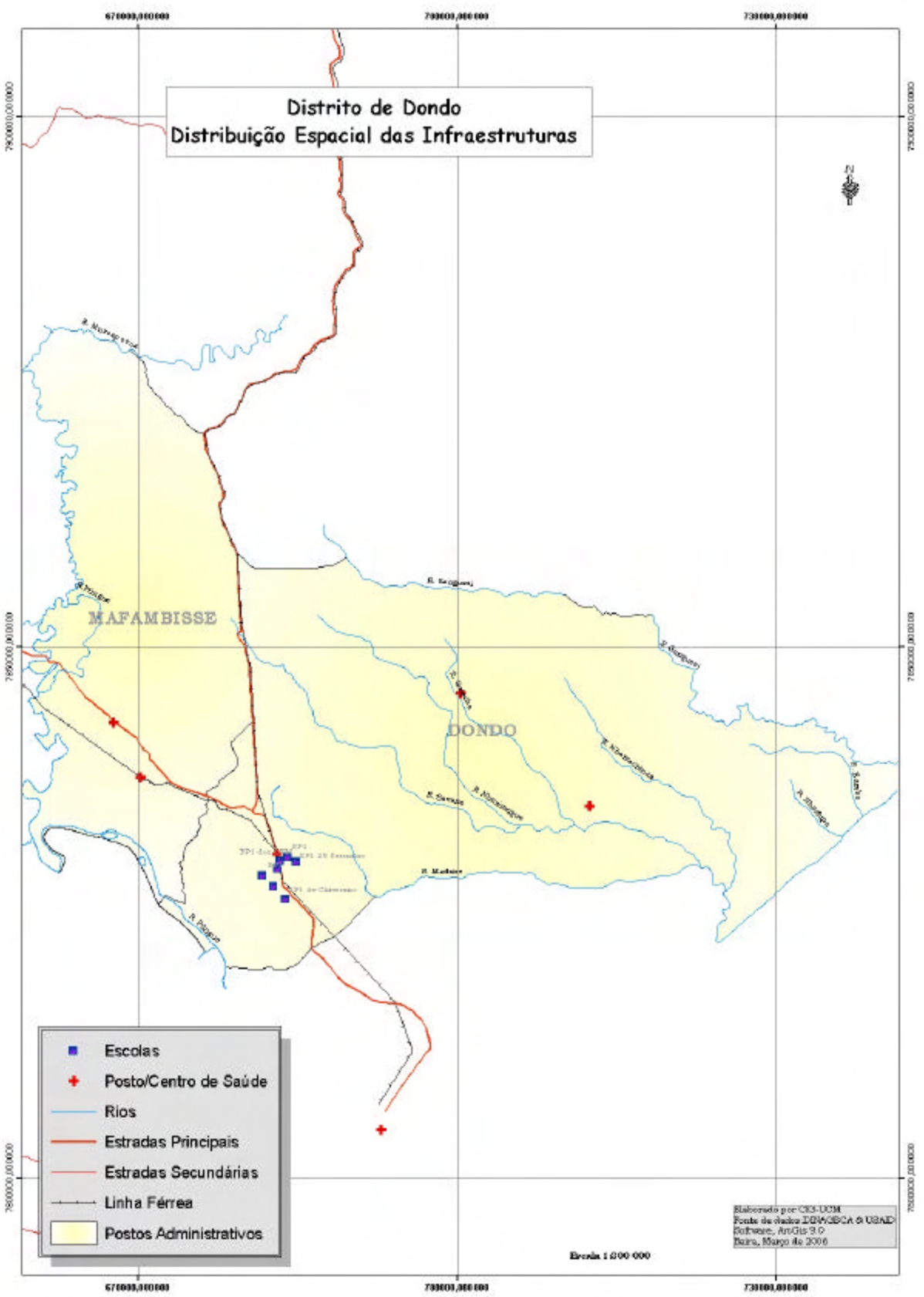

Cidade da Beira
Divisão Administratuvo por Unidades
Ndunda
Chingussura
Nhaconjo
Alto da Manga
Manga Mascarenha
Vaz
Munhava
Pioneiros
Chota
Esturro
Chaimite
Ponta Gea
Matacuane
Macurungo
Macuti
Chipangara
Escala 1: 40000

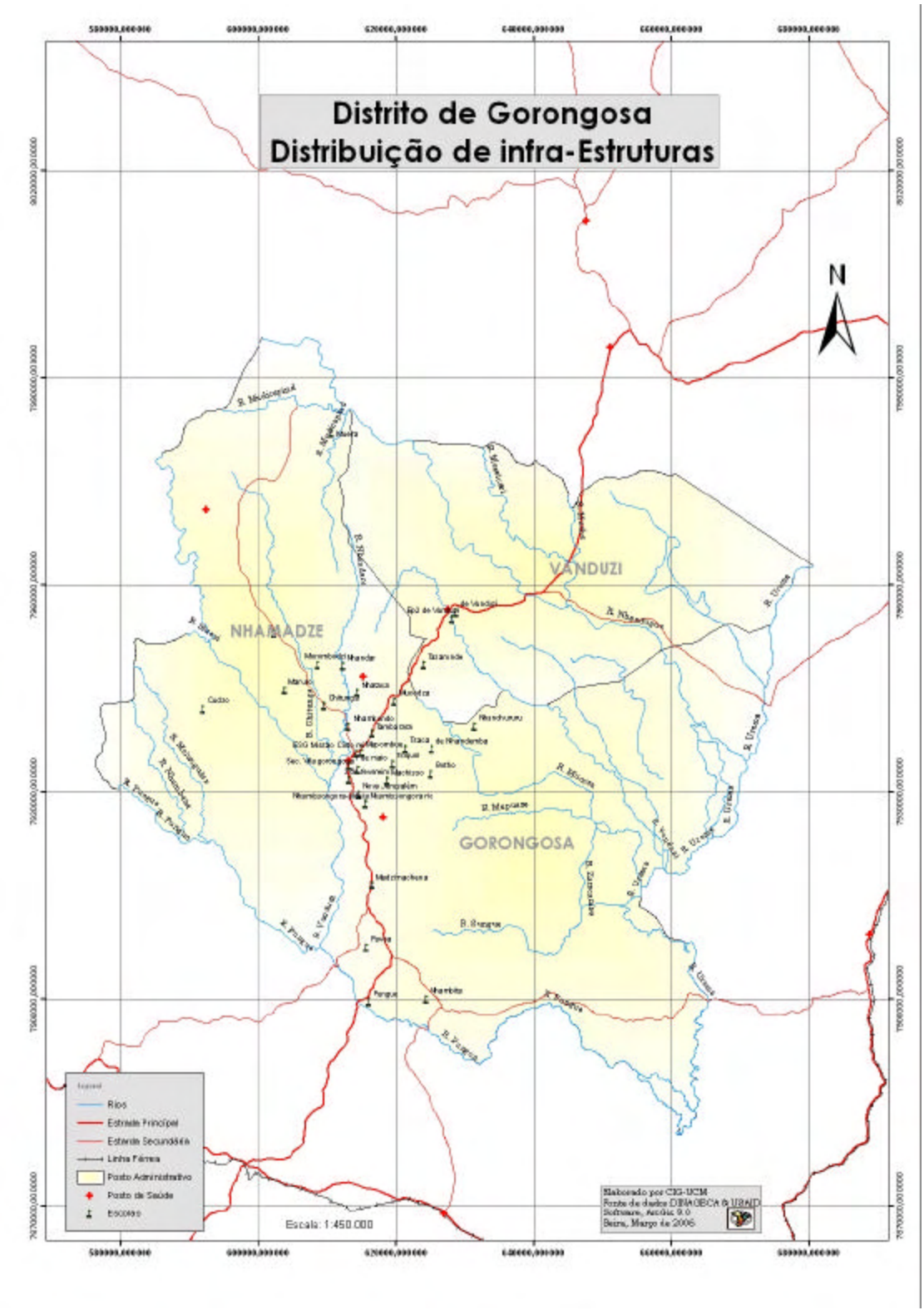

Distrito de Búzi
Distribuição de Infra-Estrutura
N
BUZI
ESTAQUINHA
NOVA SOFALA
Posto de Saúde
Escolas
Tipo de Estrada
Principal
Secundária
Linha Ferrea
Posto Administrativo
Escala 1:450 000
Elaborado por CIG-UCM
Beira, Março de 2006

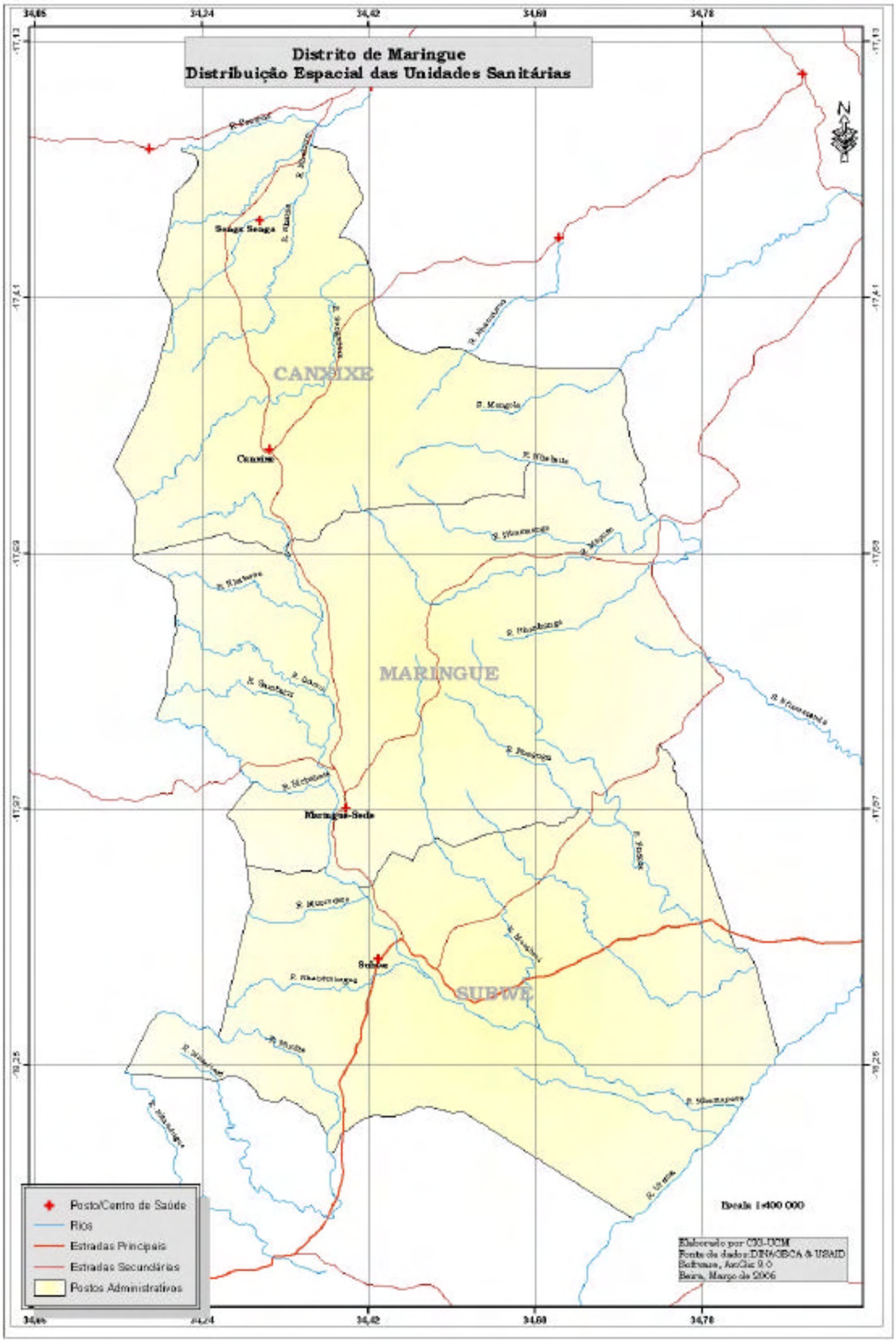

Distrito de Caia
Distribuição de Infra-Estruturas
N
SENA
MURRAÇA
CAIA
Rios
Sede do Posto administrativo
Estrada Principal
Estrada Secundária
Linha Férrea
Limite do Distrito
Posto Administrativo
Elaborado por CEG-UCM
Fonte de dados: DINAGECA & USAID
Software, ArcGis 9.0
Beira, Março de 2006

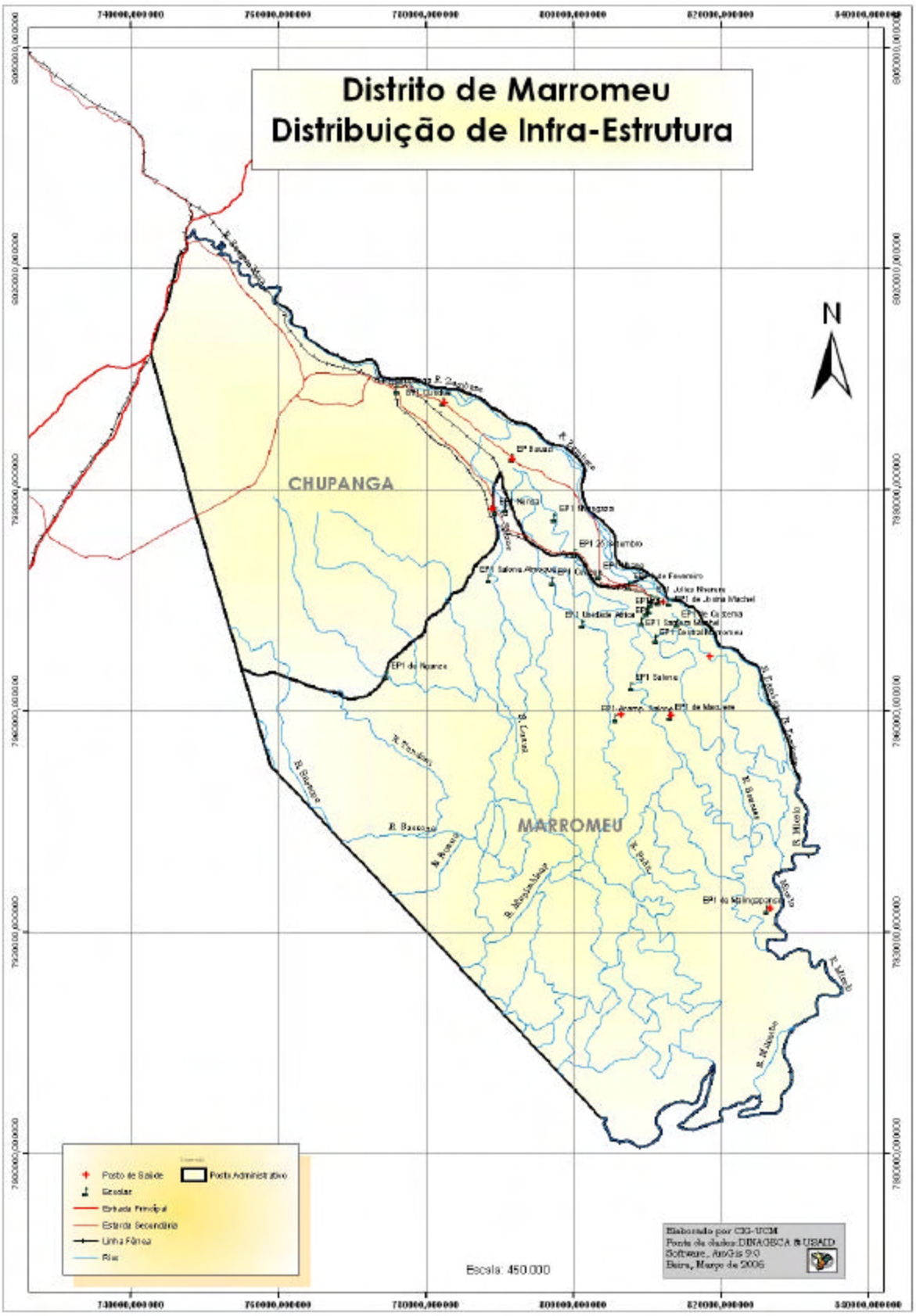

Distrito de Chemba
Distribuição Espacial de Infraestruturas
CHIRAMBA
CHEMBA
MULIMA
Posto/Centro de Saúde
Escolas
Rios
Estradas Principais
Estradas Secundárias
Linha Férrea
Postos_Administrativos
0 4.690 9.380 18.760 28.140 37.520
meters

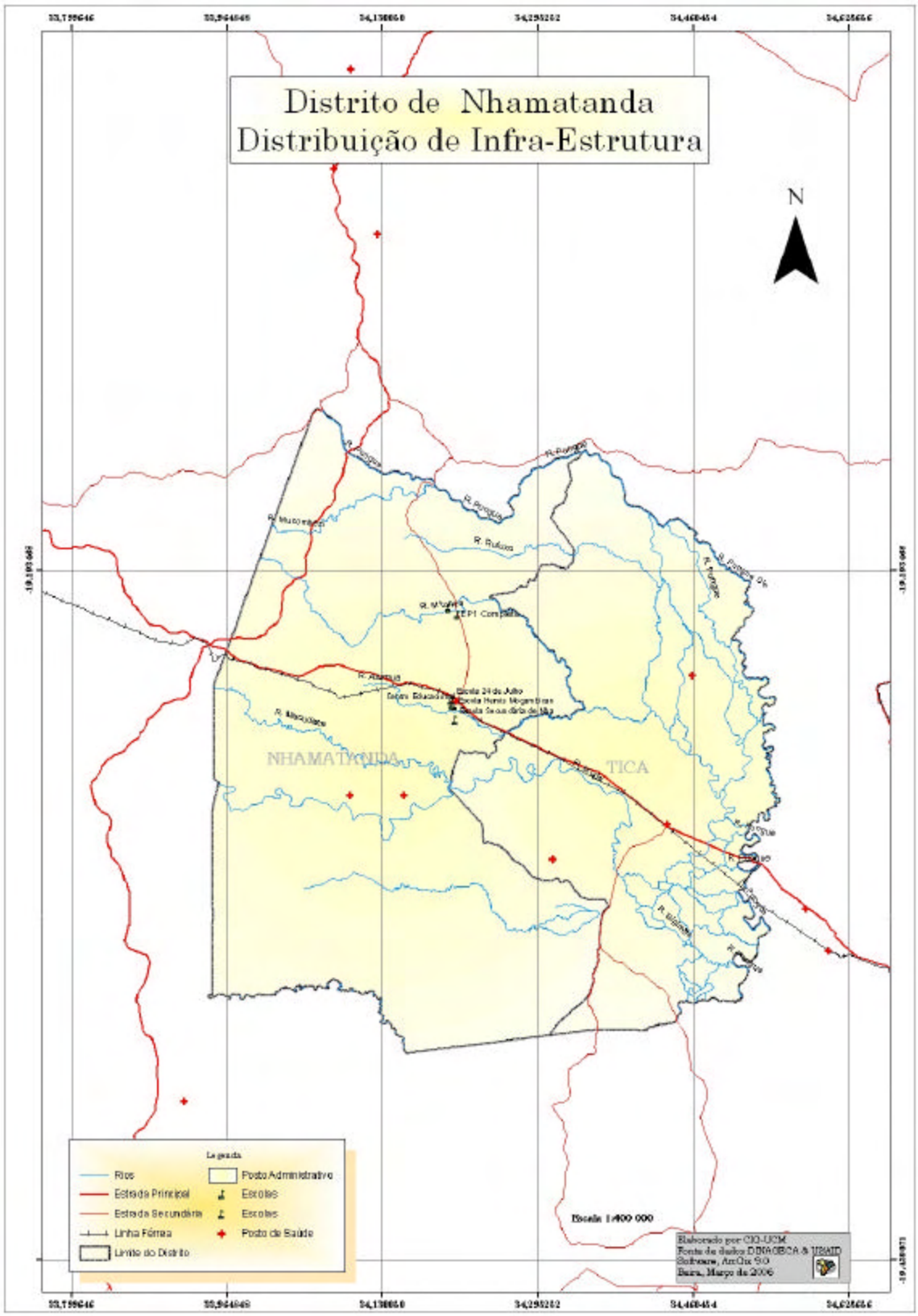

Distrito de Chibabava
Distribuição Espacial das Infraestruturas
GOONDA
CHIBABAVA
MUXUNGUE
C Saude de Tronga
Escolas
Rios
Estradas
Postos Administrativos
Posto/Centro de Saúde
Escala 1:450 000


Distrito de Dondo
Distribuição Espacial das Infraestruturas
MAFAMBISSE
DONDO
Escolas
Posto/Centro de Saúde
Rios
Estradas Principais
Estradas Secundárias
Linha Férrea
Postos Administrativos


Distrito de Gorongosa
Distribuição de infra-Estruturas
N
VANDUZI
NHAMADZE
GORONGOSA
Rios
Estrada Principal
Estrada Secundária
Linha Férrea
Posto Administrativo
Posto de Saúde
Escolas
Escala: 1:450.000
Elaborado por CEG-UCM
Fonte de dados DINAGECA & USAID
Software, ArcGis 9.0
Beira, Março de 2006


Distrito de Maringue
Distribuição Espacial das Unidades Sanitárias
CANDIXE
MARINGUE
SUBUE
Senga Senga
Candixe
Maringue-Sede
Subue
N
Posto/Centro de Saúde
Rios
Estradas Principais
Estradas Secundárias
Postos Administrativos
Escala 1:400 000
Elaborado por CEI-UCM
Fonte de dados:DINAGECA & USAID
Software, ArcGis 9.0
Beira, Março de 2006


Distrito de Marromeu
Distribuição de Infra-Estrutura
N
CHUPANGA
MARROMEU
Posto de Saúde
Escolas
Estrada Principal
Estrada Secundária
Linha Férrea
Rios
Posto Administrativo
Escala: 450.000


Distrito de Nhamatanda
Distribuição de Infra-Estrutura
N
NHAMATANDA
TICA
Legenda
Rios
Estrada Principal
Estrada Secundária
Linha Férrea
Limite do Distrito
Posto Administrativo
Escolas
Escolas
Posto de Saúde
Escala 1:400 000
Elaborado por CIG-UCM
Fonte de dados DINAGECA & USAID
Software, ArcGis 9.0
Beira, Março de 2006

ANNEX 3: Report of Baseline Assessment

(SEE SEPARATE FILE)

ANNEX 4: Agreements

MEMORANDUM OF UNDERSTANDING

BETWEEN

***Health Alliance International/Mozambique (HAI)* and Food for the Hungry Mozambique (FH/Moz)**
"Achieving Equity, Coverage, and Impact through a Care Group Network"

(USAID AWARD NO. *GHS-A-00-05-0014-00*)

INTRODUCTION

This Memorandum of Understanding (MOU) provides general guidance to Health Alliance International/Mozambique (HAI) as a local Associate Partner in Mozambique under the CSHGP Expanded Impact Child Survival Program: Achieving Equity, Coverage, and Impact through a Care Group Network, which is managed by Food for the Hungry Mozambique (FH/Moz) on behalf of Food for the Hungry, Inc. (FHUS).

PURPOSE OF THE MOU

The purpose of this MOU is to set forth the terms of collaboration between FH/Moz and HAI relevant to the implementation of the Expanded Impact Child Survival Program to be carried out in Sofala Province, Mozambique.

PERIOD AND TERMS OF THE MOU

This MOU will take effect on the day that the responsible parties from both FH/Moz and HAI have signed it and will remain in effect through the completion date of the CSHGP Expanded Impact Program, September 30, 2010, unless terminated prior to that date as specified in the Termination section below. The parties to this MOU will engage in periodic consultations in order to review its implementation. This MOU may be modified at any time, provided that such modification is by mutual consent and in writing.

PROGRAM OBJECTIVES

The Expanded Impact Child Survival Program collaboration defined in the present MOU has as its specific objectives to:

1. Improve child nutritional status
2. Assure appropriate diarrheal case management (including proper feeding during diarrhea)
3. Increase the proportion of mothers of young children who have access to an IMCI-trained provider within one hour of their home
4. Assure the sustainability, quality and expansion of the Care Group model in Mozambique

BENEFICIARIES

FHI/Moz estimates the beneficiary population to be 155,658 people – 126,149 children and 29,509 pregnant women in ten districts of Sofala province – Caia, Chemba, Meringue, Marrameu, Beira, Dondo, Gorongosa, Nhamatnada, Chibabava, and Buzi.

GOVERNANCE STRUCTURE

1. Food for the Hungry, Inc. (FHUS) is the recipient of the CSHGP award and will be fully responsible to USAID for all aspects of program management.

2. A Child Survival (CS) Coordination Team will be established to guide the implementation of

program activities. The CS Coordination Team will be led and managed by FH/Moz and will include representatives from the provincial MOH, HAI, PWCSA, AISPO (pending), and CUAAM.

3. The CS Coordination Team (led by FH/Moz) will report to and be responsible to FHUS regarding all aspects of CSHGP program implementation.

RESPONSIBILITIES OF FH/Moz and HAI:

FHI/Moz

1. Representatives of HAI (peer counselors/activists) will be invited to participate in project trainings to include but not be limited to Care Group Modules, Quality improvement and verification checklists, the Hearth nutritional rehabilitation model, conducting mini-KPC (Knowledge, Practice and Coverage) surveys and anthropometry..

2. FH/Moz will regularly share program results and information regarding the Expanded Impact Child Survival program via CS Coordination team meetings, annual reports and an annual review meeting with HAI.

HAI

1. HAI will participate in the development of and Care Group training lessons focused on HIV/AIDS – specifically related to PMTCT and available testing and treatment services provided by HAI in Sofala. HAI will also participate in the training of promoters using these lesson plans.

2. HAI will participate in meetings of the CS Coordination Team and regularly identify ways in which the program can be strengthened given their health experience in Sofala province.

3. HAI will identify ways in which the Care Group model and other methods used by FH/Moz in the CS program can be integrated into their current and future projects in order to achieve better coverage and results.

INDEMNIFICATION

Each Partner shall indemnify and hold harmless the other Partners and their officers, directors, employees and agents from and against any and all claims, demands, liabilities, fines, losses and expenses (including reasonable attorneys' fees) and other costs caused by the gross negligence, recklessness, intentional wrongdoing or fraud of the indemnifying Implementing Partner in connection with this MOU.

DISPUTE RESOLUTION

Any dispute, controversy or claim arising with respect to the interpretation and application of the present MOU will be solved by the parties involved. After resolving a conflict, an agreement will be written by both parties and will become an addendum to this MOU.

TERMINATION

HAI or FH/Moz may terminate its participation under this MOU by providing 60 days written notification.

SIGNATURE

In witness hereof, HAI and FH/Moz hereto acting through their duly authorized respective official representatives have hereby offered their seals and their respective signatures.

10/4/6
Date

Adriaan Korevaar
Country Director
FHI/Mozambique

11/04/06
Date

Dr. Pablo Montoya, MPH
Provincial Coordinator
Health Alliance International/Mozambique

PH

Direcção Provincial da Mulher e Coordsenação da Ação Social de Sofala (DPMAS) e Fundação Contra Fome Internacional, Moçambique (FHI/Moz)
"Alcançando Equidade, Cobertura, e Impacto através de uma Rede de Grupo de Cuidado"

(USAID AWARD NO. *GHS-A-00-05-0014-00*

INTRODUÇÃO

Este Memorando de Entendimento (ME) providencia orientação geral à Direcção Provincial da Mulher e Coordenação da Acção Social (DPMAS) como um parceiro associado local em Moçambique em nome do Programa de Impacto da Expansão de Sobrevivência Infantil,CSHGP. Alcançando Equidade, Cobertura, e Impacto por uma Rede de Grupo de Cuidado que é administrada através de Fundação Contra Fome Moçambique (FH/Moç) em nome da Fundação Contra Fome, Inc. (FHUS).

PROPÓSITO DO MEMORANDO DE ENTENDIMENTO

O propósito deste Memorando de Entendimento é estabelecer as condições de colaboração entre a FHI/Moç e DPMAS pertinente para a implementação do Programa de Expansão do Impacto de Sobrevivência Infantil a ser levado a cabo na Província de Sofala, Moçambique.

PERÍODO E CLÁUSULAS DO MEMORANDO

Este MEMORANDO entrará em vigor no dia que as partes responsáveis da FH/Moç. e DPMAS assinarem o presente documento e permanecerá em efeito até a data de conclusão do Programa de Expansão do Impacto de Sobrevivencia Infantil, aos 30 de Setembro de 2010, a não ser que terminasse antes dessa data como especificado na secção de Terminação abaixo. As partes deste Memorando se ocuparão de consultas periódicas para revisar sua implementação. Este Memorando pode ser modificado a qualquer altura, contanto que tal modificação seja por consentimento mútuo e por escrito.

OBJETIVOS DO PROGRAMA

A colaboração do Programa de Impacto de Sobrevivência Infantil definida no Memorando presente tem como seus objetivos específicos o seguinte:

1. Melhorar o estado nutricional da criança
2. Assegurar a gestão/administração apropriada dos casos diarreicos (incluindo própria alimentação durante a diarréia)
3. Aumentar a proporção de mães de crianças pequenas com acesso a um provedor de AIDI-treinado, numa distancia de percurso de uma hora andando das suas casas.
4. Assegurar a sustentabilidade, qualidade e expansão do modelo de Grupo de Cuidado em Moçambique

BENEFICIÁRIOS

A FHI/Moç. calcula a população de beneficiários sendo de 155,658 pessoas dos quais 126,149 são crianças e 29,509 mulheres grávidas em dez distritos da província de Sofala - Caia, Chemba, Maringue, Marromeu, Beira, Dondo, Gorongosa, Nhamatanda, Chibabava e Buzi.

ESTRUTURA DE ADMINISTRAÇÃO

1. Fundação Contra Fome, Inc. (FHUS) é o recipiente do prêmio de CSHGP e será completamente responsável à USAID por todos os aspectos de administração do programa.

2. Uma Equipa de Coordenação de Sobrevivência Infantil (SI) será estabelecida para guiar a implementação de actividades do programa. A Equipa de Coordenação será conduzidoa e administrada por FH/Moç. e incluirá os representantes provinciais do MISAU (DPS), HAI, DPMCAS, AISPO (pendente), e CUAAM.

3. A Equipa de Coordenação de SI (conduzida por FH/Moç.) informará e será responsável à FHUS em relação a todos os aspectos da implementação do programa CSHGP.

RESPONSABILIDADES DA FH/Moç. e DPMAS:

FHI/Moç.

1. Os representantes da DPMAS, serão convidados a participar em treinamentos do projeto por realizar mas não serão limitados a apenas Módulos de Grupo de Cuidado, melhoria de Qualidade e listas de verificação de control de qualidade, Hearth(papas) modelo de reabilitação nutricional, administração de míni-CPC (Conhecimento, Prática e Cobertura) pesquisas e antropometria.

2. A FHI/Moç. compartilhará regularmente os resultados do programa e informação relacionada ao Progarama de Expansão do Impacto de Sobrevivência Infantil através de coordenação entre promotores da FHI/Moç ao nível distrital e os comités comunitários da Acçã Social, reuniões de Coordenação da equipa de SI, relatórios anuais e uma reunião de revisão anual com toda DPMAS..

DPMCAS

1. Os comités comunitários de DPMAS facilitarão atividades de censo da comunidade, o recrutamento de Mães Chefes e as participações de mães beneficiárias nas atividades do Programa de Expansão do Impacto de Sobrevivencia Infantil,

2. DPMAS participará em reuniões da Equipa de Coordenação e regularmente identificará modos nos quais o programa pode ser fortalecido devido às suas experiências de saúde na província de Sofala.

3. DPMAS identificará modos nas quais o modelo de Grupo de Cuidado e outros métodos usados por FH/Moç. no programa de SI podem ser integrados nos seus projetos atuais e futuros para alcançar melhor cobertura e resultados.

INDENIZAÇÃO

Cada parceiro sera responsável pela indenizacao sem afectar os outros parceriros os seus oficiais, diretores, empregados e agentes de e contra qualquer e todas as reivindicações, demandas, responsabilidades, multas, perdas e despesas (incluindo as taxas de advogados razoáveis) e outros custos causados pela negligência total, descuido, mal intencional ou fraude do parceiro Implementador da indenização com relação a este MEMORANDO

RESOLUÇÃO DE DISPUTA

Qualquer disputa, controvérsia ou reivindicação que surgem com respeito à interpretação e aplicação do MEMORANDO presente serão resolvidas pelas partes envolvidas. Depois de solucionar um conflito, um acordo será escrito através das partes e se tornará uma adenda a este MEMORANDO.

TERMINAÇÃO

A DPMAS ou FHI/Moç. podem terminar sua participação de acordo com este MEMORANDO provendo notificação escrita no periodo de 60 dias.

ASSINATURA

Em testemunho presente, a DPMAS e FHI/Moç. que agem até aqui através dos seus respectivos representantes oficiais propriamente autorizados ofereceram por este meio os seus carimbos e as suas respectivas assinaturas .

31/3/6
Data

Adriaan Korevaar
Diretor Nacional

FHI/Moçambique

03/04/06
Data

Sra. Antônia Charre
Directora Provincial da Mulher e
Coordinacao da Accao Social

Sofala

MEMORANDUM OF UNDERSTANDING

BETWEEN

Doctors with Africa (CUAMM) and Food for the Hungry Mozambique (FH/Moz)

"Achieving Equity, Coverage, and Impact through a Care Group Network"

(USAID AWARD NO. *GHS-A-00-05-0014-00)*

INTRODUCTION

This Memorandum of Understanding (MOU) provides general guidance to Doctors with Africa (CUAMM) as a local Associate Partner in Mozambique under the CSHGP Expanded Impact Child Survival Program: Achieving Equity, Coverage, and Impact through a Care Group Network, which is managed by Food for the Hungry Mozambique (FH/Moz) on behalf of Food for the Hungry, Inc. (FHUS).

PURPOSE OF THE MOU

The purpose of this MOU is to set forth the terms of collaboration between FH/Moz and CUAMM relevant to the implementation of the Expanded Impact Child Survival Program to be carried out in Sofala Province, Mozambique.

PERIOD AND TERMS OF THE MOU

This MOU will take effect on the day that the responsible parties from both FH/Moz and CUAMM have signed it and will remain in effect through the completion date of the CSHGP Expanded Impact Program, September 30, 2010, unless terminated prior to that date as specified in the Termination section below. The parties to this MOU will engage in periodic consultations in order to review its implementation. This MOU may be modified at any time, provided that such modification is by mutual consent and in writing.

PROGRAM OBJECTIVES

The Expanded Impact Child Survival Program collaboration defined in the present MOU has as its specific objectives to:

1. Improve child nutritional status
2. Assure appropriate diarrheal case management (including proper feeding during diarrhea)
3. Increase the proportion of mothers of young children who have access to an IMCI-trained provider within one hour of their home
4. Assure the sustainability, quality and expansion of the Care Group model in Mozambique

BENEFICIARIES

FHI/Moz estimates the beneficiary population to be 155,658 people – 126,149 children and 29,509 pregnant women in ten districts of Sofala province – Caia, Chemba, Meringue, Marrameu, Beira, Dondo, Gorongosa, Nhamatnada, Chibabava, and BuziBuzi.

GOVERNANCE STRUCTURE

1. Food for the Hungry, Inc. (FHUS) is the recipient of the CSHGP award and will be fully responsible to USAID for all aspects of program management.

2. A Child Survival (CS) Coordination Team will be established to guide the implementation of program activities. The CS Coordination Team will be led and managed by FH/Moz and will

include representatives from the provincial MOH, HAI, PWCSA, AISPO (pending), and CUAMM.

3. The CS Coordination Team (led by FH/Moz) will report to and be responsible to FHUS regarding all aspects of CSHGP program implementation.

RESPONSIBILITIES OF FH/Moz and CUAMM:

FHI/Moz

1. Representatives of CUAMM will be invited to participate in project trainings to include but not be limited to Care Group Modules, Quality improvement and verification checklists, the Hearth nutritional rehabilitation model, conducting mini-KPC (Knowledge, Practice and Coverage) surveys and anthropometry

2. FH/Moz will regularly share program results and information regarding the Expanded Impact Child Survival program via CS Coordination team meetings, annual reports and an annual review meeting with CUAMM.

3. FH/Moz will refer children, aged 0-59mth, identified as severely malnourish during HEARTH screenings in the district of Manga, to CUAMM's feeding center in Beira.

CUAMM

1. CUAMM's feeding center in Beira will provide treatment for severely malnourished children referred by FH/Moz.

2. CUAMM will provide community based therapeutic feeding, using "plumpy nut" in tandem with FH/Moz HEARTH activities.

3. CUAMM will participate in meetings of the CS Coordination Team and regularly identify ways in which the program can be strengthened given their health experience in Sofala province.

4. CUAMM will identify ways in which the Care Group model and other methods used by FH/Moz in the CS program can be integrated into their current and future projects in order to achieve better coverage and results

INDEMNIFICATION

Each Partner shall indemnify and hold harmless the other Partners and their officers, directors, employees and agents from and against any and all claims, demands, liabilities, fines, losses and expenses (including reasonable attorneys' fees) and other costs caused by the gross negligence, recklessness, intentional wrongdoing or fraud of the indemnifying Implementing Partner in connection with this MOU.

DISPUTE RESOLUTION

Any dispute, controversy or claim arising with respect to the interpretation and application of the present MOU will be solved by the parties involved. After resolving a conflict, an agreement will be written by both parties and will become an addendum to this MOU.

TERMINATION

CUAMM or FH/Moz may terminate its participation under this MOU by providing 60 days written notification.

SIGNATURE

In witness hereof, CUAMM and FH/Moz hereto acting through their duly authorized respective official representatives have hereby offered their seals and their respective signatures.

_____	_____
Date	Date
_____	_____
Adriaan Korevaar Country Director FHI/Mozambique	***[CUAMM representative]***

MEMORANDUM OF UNDERSTANDING

BETWEEN

Sofala Provincial Ministry of Health (MOH) and Food for the Hungry International, Mozambique (FHI/Moz)

"Achieving Equity, Coverage, and Impact through a Care Group Network"

(USAID AWARD NO. *GHS-A-00-05-0014-00)*

INTRODUCTION

This Memorandum of Understanding (MOU) provides general guidance to MOH as a local Implementing Partner in Mozambique on behalf of the CSHGP Expanded Impact Child Survival Program: Achieving Equity, Coverage, and Impact through a Care Group Network of which Food for the Hungry, US was awarded on behalf of Food for the Hungry/Mozambique.

PURPOSE OF THE MOU

The purpose of this MOU is to set forth the terms of the collaboration between FH/Moz and MOH relevant to the implementation of the Expanded Impact Child Survival Program to be carried out in Sofala province.

PERIOD AND TERMS OF THE MOU

This MOU will take effect on the day that the responsible parties from both FH/Moz and MOH have signed it and will remain in effect through the completion date of the CSHGP Expanded Impact Program, September 30, 2010. The parties to this MOU will engage in periodic consultations in order to review its implementation. This MOU may be modified at any time, provided that such modification is by mutual consent and in writing.

PRGRAM OBJECTIVES

The Expanded Impact Child Survival Program collaboration defined in the present MOU has as its specific objectives to:

5. Improve child nutritional status
6. Assure appropriate diarrheal case management (including proper feeding during diarrhea)
7. Increase the proportion of mothers of young children who have access to an IMCI-trained provider within one hour of their home
8. Assure the sustainability, quality and expansion of the Care Group model in Mozambique

BENEFICIARIES

FHI/Moz estimates the beneficiary population to be 155,658 people – 126,149 children and 29,509 pregnant women in ten districts of Sofala province – Caia, Chemba, Meringue, Marrameu, Beira, Dondo, Gorongosa, Nhamatnada, Chibabava, and Buzi.

GOVERNANCE STRUCTURE

4. Food for the Hungry, Inc. (FHUS) is the recipient of the CSHGP award and will be fully responsible to USAID for all aspects of program management.

5. A Child Survival (CS) Coordination Team will be established to guide the implementation of

program activities. The CS Coordination Team will be led and managed by FH/Moz and will include representatives from the provincial MOH, HAI, PWCSA, AISPO (pending), and CUAMM.

6. The CS Coordination Team (led by FH/Moz) will report to and be responsible to FHUS regarding all aspects of CSHGP program implementation.

RESPONSIBILITIES OF FH/Moz and MOH:

FH/Moz

1. Representatives of the MOH will be invited to participate in project trainings to include but not be limited to Care Group Modules, Quality improvement and verification checklists, the Hearth nutritional rehabilitation model, conducting mini-KPC (Knowledge, Practice and Coverage) surveys and anthropometry.

2. FHI/Moz trained Promoters and Leader Mothers who prove themselves to be competent will be authorized to distribute ORS, Vit A supplements and deworming medication (Albendazole or Mebendazole) at the community level (through the Care Group structure) during the implementation of the Expanded Impact Child Survival Program. FHI/Moz will conduct bi-annual malnutrition screenings for children 0-59 months of age during which children 12 months and older will receive 400 mg of Albendazole (or 500mg of Mebendazole in a single dose), and children aged 6 months and older will received Vit A supplements. Postpartum mothers will also receive one dose of Vitamin A within 40 days postpartum. Children who have measles, severe infections, or severe malnutrition will also receive a regimen of vitamin A per international treatment norms. Mothers of children suffering from diarrhea will be provided ORS packets throughout the life of the program.

3. FH/Moz will regularly share program results and information regarding the Expanded Impact Child Survival program via quarterly CS Coordination team meetings, annual reports and an annual review meeting with all project partners.

MOH AS AN EXPANDED IMPACT CS PROGRAM IMPLEMENTATION PARTNER

1. The District level MOH representative will help facilitate community census activities, the recruitment of Leader Mothers and the participation of beneficiary mothers in the activities of the Expanded Impact Child Survival Program.

2. The MOH will provide, free of charge, Community IMCI trainers for the training of FHI/Moz and partner staff in C-IMCI.

3. The MOH will provide, free of charge, Vit A, Albendazole (or Mebendazole), and ORS packets in the amounts specified below for the direct beneficiary population of the Expanded Impact Child Survival Program**:**

	Year 1	Year 2	Year 3	Year 4	Year 5	Total
Mebendazole/Albendazole Doses	37,635	38,876	101,171	104,498	107,946	**390,126**
Vitamin A Doses	84,679	87,472	227,635	235,120	242,879	**877,785**
ORS Packets	150,541	155,505	404,684	417,992	431,785	**1,560,507**
Iron Supplements	523,750	1,355,763	4,533,209	4,637,560	4,842,247	**15,832,529**

4. District level MOH officials from the ten districts in Sofala province in which program activities are being implemented will accompany FHI/Moz staff quarterly in the supervision of program Promoters.

5. As of July 1, 2010 MOH staff at district level health facilities will conduct supervision of Care Groups via an IMCI trained Leader Mothers by either visiting Leader Mothers communities or meeting with Leader Mothers at the health facilities (e.g. during regular outreach immunization posts).

INDEMNIFICATION

Each Partner shall indemnify and hold harmless the other Partners and their officers, directors, employees and agents from and against any and all claims, demands, liabilities, fines, losses and expenses (including reasonable attorneys' fees) and other costs caused by the gross negligence, recklessness, intentional wrongdoing or fraud of the indemnifying Implementing Partner in connection with this MOU.

DISPUTE RESOLUTION

Any dispute, controversy or claim arising with respect to the interpretation and application of the present MOU will be solved by the parties involved. After resolving a conflict, an agreement will be written by both parties and will become an addendum to this MOU.

TERMINATION

The MOH or FH/Moz may terminate its participation under this MOU by providing 60 days written notification.

SIGNATURE

In witness hereof, MOH and FH/Moz hereto acting through their duly authorized respective official representatives have hereby offered their seals and their respective signatures.

_____ _____

Date Date

_____ _____

Adriaan Korevaar
Country Director
FHI/Mozambique

Dr. Alberto João Baptista
Director
Sofala Provincial MO

IMPLEMENTING PARTNER AGREEMENT
BETWEEN
FOOD FOR THE HUNGRY, INC. (FHUS)
AND
FOOD FOR THE HUNGRY, MOZAMBIQUE (FH/MOZ)
CONCERNING
USAID COOPERATIVE AGREEMENT NO. GHS-A-00-05-00014-00

I GENERAL CONDITIONS

1.1 As per the signing of this agreement, Food for the Hungry, Inc. (FHUS) and Food for the Hungry, Mozambique (FH/Moz) established a formal partnership with FHUS being the "Recipient" and FH/Moz being the "Implementing Partner";

1.2 The Implementing Partner intrinsic to this Agreement is authorized under USAID Cooperative Agreement No. GHS-A-00-05-00014-00 *(see Award Agreement, Appendix 1)*;

1.3 This Implementing Partner Agreement is effective and obligation is made as of the date of signature of this Implementing Partner Agreement Agreement, and funds obligated hereunder according to the attached award agreement, budget which shall be used in reimbursement to the Implementing Partner for the allocable program expenditures in furtherance of the agreed program objectives as per the original program plan laid out in Cooperative Agreement No. GHS-A-00-05-00014-00 during the period beginning October 1, 2005 and ending September 30, 2010.

1.4 This Implementing Partner Agreement is made to the Implementing Partner on condition that the funds will be administered in accordance with the terms and conditions as set forth in 22 CFR 226, entitled "Administration of Assistance Awards to US Non-Government Organization", Office of Management and Budget ("OMB") Circulars A-122, A-133, and Cooperative Agreement No. GHS-A-00-05-00014-00;

1.5 In Standard Provisions and in all instances in the aforementioned documentation (clause 1.4) where the US Government is named, "Food for the Hungry, Inc." will be substituted for the US Government, and "Food for the Hungry, Int', Mozambique " will be substituted for "Recipient".

1.6 This Implementing Partner Agreement is subject to USAID's ultimate rights as provided in its agreements with FHUS, to approve items, request changes, effect work continuance or termination, make adjustments and settlements or payments, revise time schedules and request financial and other information and data. Funds provided through this Implementing Partner Agreement shall be used only for those activities necessary to complete the Program as described in the approved program proposal *(see Program Proposal, Appendix 2)*.

1.7 Equipment, Source and Nationality of suppliers of goods and services purchased by the Implementing Partner under this Implementing Partner Agreement shall be vested with the US Government. The Implementing Partner shall use, maintain, insure, and account for equipment, and in all other ways comply with 22 CFR 226, 30 through 37. After termination of the project, the disposition of said equipment/property will be decided as per instructions given by USAID through the Recipient.

1.8 The authorized geographic code for procurement of goods and services under this award is 935.

1.9 In addition to provision under the Standard Provisions, this Program can be terminated when the award period is finished September 30, 2010 or if current funding is ceased before the official termination date in this Implementing Partner Agreement Agreement.

1.10 Any disputes or disagreements arising during implementation of the project will be dealt with promptly with open dialogue and negotiation. Final arbitration authority for disputes occurring among multiple parties, and concerning members of both FH/MOZ and FHUS staff will be decided by a panel of arbitrators elected by the parties involved in the dispute.

1.11 This agreement will take effect from October 1, 2005 as indicated in the Cooperative Agreement No. GHS-A-00-05-00014-00 signed between FHUS and USAID and end on September 30, 2010 or the end date of a USAID-approved extension.

2 BUDGET CONDITIONS

2.1 The Approved Budget and Budget Narrative for the Implementing Partner is *Appendix 3*.

2.2 The Implementing Partner understands that FHUS might be required to submit a revised budget and other documentation to USAID for each year of the Award and that Appendix 3 will be amended for each year of the term hereof to reflect changes to the award budget as approved by USAID.

2.3 In applying and accounting for funds made available pursuant to this Implementing Partner Agreement to carry out the purpose of this Implementing Partner Agreement, the Implementing Partner shall adhere to the applicable cost principles of OMB Circular A-122 and its determination of reasonable, allocable and allowable costs;

2.4 Revisions to the budget shall be made only in accordance with the terms of 22 CFR 226.25 *(see Appendix 4)*.

3 RESPONSIBILITIES OF FHUS

3.1 FHUS agrees to provide financial and technical support for the implementation of approved project activities, as per agreed parameters provided in the approved proposal;

3.2 FHUS shall be obligated to make payments to the Implementing Partner only for cost items that are included in the budget and that are allowable under OMB Circular A-122.

3.3 FHUS may, at their own discretion, perform an onsite visit or choose an outside auditor to review the Implementing Partner 's accounting practices. Both FHUS and the Implementing Partner will agree on the timeframe for management decisions deadlines following the review or audit.

3.4 FHUS will ensure that all necessary steps are taken to enable the Implementing Partner to adhere to all required US Government obligations and requirements. This will include the supply, in a timely manner, by FHUS to the Implementing Partner of all the necessary technical assistance, consultation, and training, as deemed necessary by FHUS, the Implementing Partner and/or USAID;

3.5 FHUS will be responsible to the USAID to assist in thorough monitoring and evaluation of all program activities, in accordance with USAID minimum standards;

3.6 FHUS will ensure that all necessary steps are taken to enable the Implementing Partner to adhere to stated budget, finance and auditing requirements;

3.7 FHUS will utilize a reimbursement system when transferring funds to the Implementing Partner. That is, upon receipt of a financial report from the Implementing Partner which details program expenses already incurred, FHUS will utilize a Letter of Credit drawdown system to access funds from USAID and will then transfer, via the FH/ISC (Food for the Hungry International Service Center) those funds to the Implementing Partner as reimbursement for said expenses incurred.

3.8 As per USAID approval, FHUS' current approved NICRA rate of 12.52% has been applied to the entire amount of the grant. That said, this rate can and most likely will change over the life of the grant. The actual amount of NICRA that will be recovered by FHUS (and by extension the Implementing Partner) over the life of the program is based both on fluctuations of FHUS' NICRA rate and the actual grant expenses that are incurred over the life of the program.

3.10 During the life of the project, FHUS staff or consultants may visit any of the program sites to conduct monitoring and evaluation activities.

4 RESPONSIBILITIES OF THE IMPLEMENTING PARTNER

4.1 As the Implementing Partner in this Implementing Partner Agreement, FH/MOZ hereby agrees to implement all elements of the project as previously agreed, and defined in the approved project proposal;

4.2 The Implementing Partner will submit cash reimbursement requests to FH/ISC, who in turn will submit a draw down request to FHUS as a prerequisite for allocation of USAID funds from the Recipient to the Implementing Partner ;

4.3 As per the guidelines and regulations concerning the use of US Government fund, the Implementing Partner shall not procure any of the following foods and/or services using USAID funds without prior, written authorization of USAID through the Recipient:

(a) agricultural commodities;
(b) motor vehicles;
(c) pharmaceuticals
(d) pesticides
(e) rubber compounding chemicals and plasticisers;
(f) used equipment;
(g) US Government owned excess property; and
(h) fertilizers

4.4 The Implementing Partner shall obtain prior written approval from USAID, through FHUS, for the purchase of "General Purpose Equipment", which is defined as an article of non-expendable tangible personal property, the use of which is not limited to research, medical, scientific or other activities (e.g. office equipment and furnishings, air conditioning equipment, reproduction or other equipment having a useful life or more than one year and an acquisition cost of US$5,000 or more per unit);

4.5 The Implementing Partner shall maintain and make available upon request all award-related records, receipts and books of accounts to the Recipient in accordance with standard accounting practice, of all transactions made under this Implementing Partner Agreement Agreement;

4.6 The Implementing Partner shall provide for disposition of all capital items purchased under this Implementing Partner Agreement as per the requirements of USAID.

4.7 The Implementing Partner shall not transfer in excess of 10% of funds between categories without notifying FHUS.

4.8 The Implementing Partner will track and provide information regarding the cost share/match of US$847,653 under this Award (including materials and supplies received from in-country partners [e.g. MOH] such as Vitamin A and Mebendazole.

4.9 The Implementing Partner shall simultaneously submit all financial reports on a quarterly basis in English to Food for the Hungry's US Headquarters in Phoenix, Arizona no later than 30 days after the end of the reporting period.

4.10 The Implementing Partner shall simultaneously submit Monthly Performance Reports to Food for the Hungry's Washington, DC office.

4.11 The Implementing Partner shall submit Annual Reports, following a format that will be provided by FHUS to the Implementing Partner, no later than 15 days after the end of the reporting period (Oct 1 – Sept 30) to Food for the Hungry's US Washington DC office.

4.12 Within 45 days of the completion date of the Implementing Partner Agreement, the Implementing Partner shall submit a copy of a comprehensive Final Report, following a format that will be provided by FHUS to the Implementing Partner in the final year of the Award;

4.13 The Implementing Partner shall ensure the submission of all required reports and documents to any host country national and/or regional authorities to which it is responsible for its execution of its portion of the program.

4.14 The Implementing Partner will be responsible to keep abreast of changes in policies, procedures and/or regulations and advise its staff of those changes.

4.15 The Implementing Partner will develop internal policies and systems to ensure effective management of federal funds and compliance with public policy regulations. The Implementing Partner shall ensure that adequate systems are in place for financial management, procurement and property management.

4.16 The Implementing Partner shall submit a copy of an audit report (if it was performed) including all management letter comments, findings or adjustments that are applicable to this award.

4.17 The Implementing Partner shall retain financial records and any substantiating documentation thereof, such as bills, invoices, canceled checks, receipts, effort reports, and any other records pertinent to this Implementing Partner Agreement for the period required by 22 CFR 226.53 or until the seventh anniversary of the Termination

Date, whichever is later. During this period FHUS or its agents shall have access to inspect, audit and make extracts from such books and records.

4.18 The Implementing Partner shall give FHUS twenty days advance notice of any intended international travel that has not been pre-approved by USAID. Travel shall be by coach class using direct routing.

4.19 The Implementing Partner assumes liability for all loss, damage, cost and expense caused by, resulting from, or arising out of the operation or performance of, or the failure to perform, any duty, obligation, or activity on the part of the Implementing Partner or any of its subcontractors, agents, or employees in connection with this Award.

4.20 The Implementing Partner should consider purchase of insurance as appropriate, as neither FHUS nor USAID will assume liability for any third party claim for damages arising out of this Award.

4.21 The Implementing Partner is expected to be in close contact with [illegible] concerning the implementation of this Award. However, FHUS will be responsible [illegible] issues with USAID/Washington. If the Implementing Partner desires to propose any [illegible] changes to USAID/Mozambique, those changes must be discussed with and approved by FHUS prior to their proposal to USAID/Mozambique.

5 DURATION, AMENDMENT OR TERMINATION OF THE AGREEMENT

5.1 This Implementing Partner Agreement will have a binding effect on both parties beginning October 1, 2005 and expiring on September 30, 2010, or the end date of a USAID-approved extension;

5.2 Any amendment to this document must be agreed up on and approved in writing by FHUS and the Implementing Partner and appended to this Implementing Partner Agreement Agreement;

5.3 This Implementing Partner Agreement may be suspended, abrogated or terminated by either party due to non-compliance with any terms of said Agreement. The intent to suspend or abrogate shall be communicated in writing and discussed by each party at least 60 days in advance. In the event of suspension of this Implementing Partner Agreement Agreement, payment of previously committed funds to the Implementing Partner from USAID, through FHUS will cease;

5.4 The following documents which are appended to this Implementing Partner Agreement constitute an integral part of this Implementing Partner Agreement Agreement, and have been consented to in their entirety by signature on this Implementing Partner Agreement Agreement:

Appendix 1: Award Agreement
Appendix 2: Approved Program Proposal
Appendix 3: Approved Budget and Budget Narrative
Appendix 4: 22 CFR 226

6 SIGNATURE

In witness, there of the undersigned, being duly authorized, have signed this Implementing Partner Agreement in Two (2) originals on behalf of FHUS and FH/MOZ, on the date and year below written.

Adriaan Korevaar	David Evans	Thomas Stocker
Country Director	Vice President, Government and GIK Relations	Vice President Africa Region
Food for the Hungry, Mozambique	Food for the Hungry, US	Food for the Hungry
12/04/2006	12/04/06	April 11, 2006
Date of Signature	Date of Signature	Date of Signature

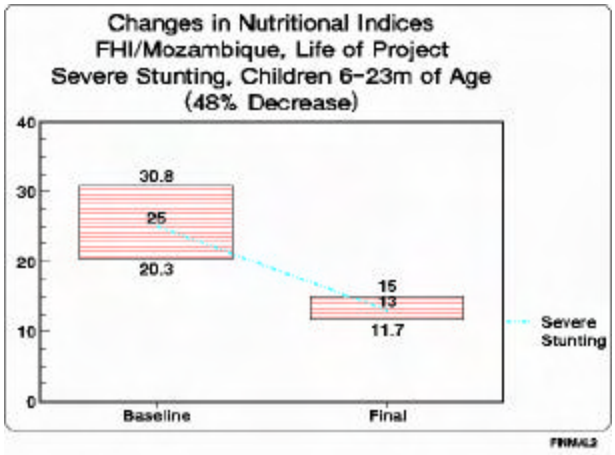
MEETING PHYSICAL AND SPIRITUAL NEEDS WORLDWIDE

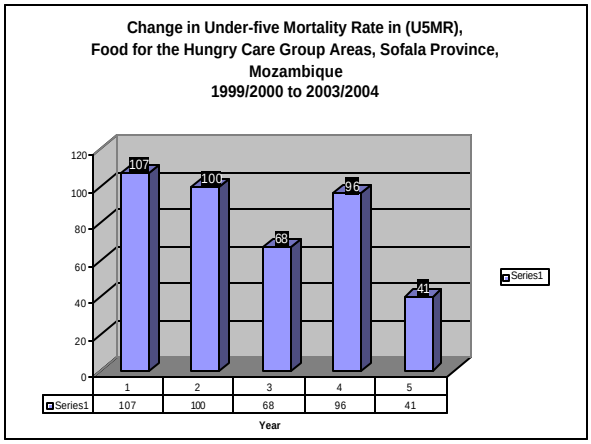
April 11, 2006

Dr. Giuseppe Bufardeci
AISPO / Mozambique

Giuseppe:
It was great meeting you and having you participate in our KPC Survey Analysis workshop in March of this year in Beira. I am including some information below that you can pass along to folks in Italy concerning this project and how we would like to have AISPO involved.

Over the next five years, Food for the Hungry (FH) will be improving the lives and survival rates of **134,146 Mozambican children and 21,521 pregnant women** located in ten districts of Sofala Provinces. We will achieve this by reducing malnutrition by one-third, helping mothers to adopt safer practices that keep children alive, and helping them to have access to critically-needed services, vitamins, and medications. Food for the Hungry's five-year (2005-2010) USAID-funded Expanded Impact Child Survival Project builds on our previous success with the "Care Group" approach. During a program from 1998-2001, FH/Mozambique **decreased moderate and severe malnutrition in preschool children living in Sofala province by 40%, severe malnutrition by 48%, and decreased the death rate of preschool children by 62%** in Sofala province in areas where the Care Group approach was utilized.



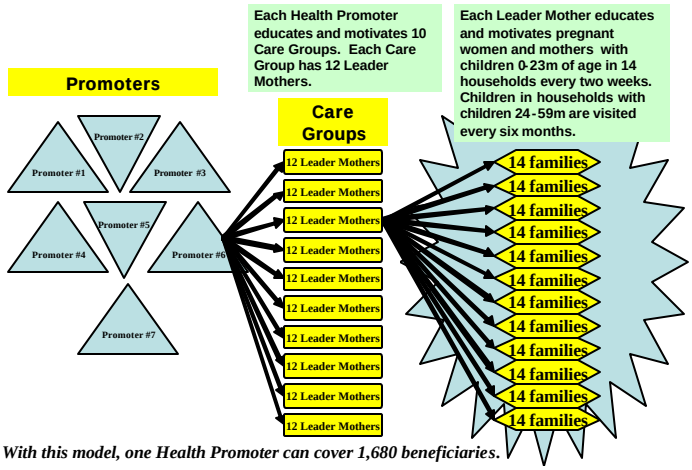


The Care Group methodology helps mothers to learn how to help their children survive and thrive, and to adopt new behaviors. FH works with health Promoters, community Leader Mothers, and mothers groups in improving nutritional practices and diarrheal disease management.

Food for the Hungry
Meeting physical and spiritual needs worldwide
1224 E. Washington St., Phoenix, AZ 85034 phone 480-998-3100 toll-free 800-2-HUNGERS fax 480-998-4806 web www.fh.org
Benjamin K. Homan, President

Each Care Group is composed of 12 "Leader Mothers." These Leader Mothers are each chosen by their neighbors and communities. Leader Mothers are educated by a Promoter every two weeks for two hours then each Leader Mother takes what she learned out to a group of 14 households with mothers of children 0-23m and pregnant women. (The PowerPoint included with the e-mail gives more details on how Care Groups function and why we think they have been so successful in improving health status.)

FHI/Mozambique Care Group Model



With this model, one Health Promoter can cover 1,680 beneficiaries.

Health messages focus on helping mothers to adopt healthier practices in terms of breastfeeding, complimentary feeding, micronutrients, nutrition during pregnancy, diarrheal home management (e.g., use of oral rehydration serum), sanitation and hygiene (e.g., proper hand washing and water purification), the need for proper home management of illnesses and knowing when children need to be seen in a health center.

This project will be carried out in the following districts of Sofala Province:

2005-2010	**Caia** (50% of population) **Chemba** **Meringue** **Marromeu** (34% of population) **Beira** (105,000 people in this district)
2008-2010	**Dondo** (50% of the population) **Gorongosa** (50% of the population) **Nhamatanda** (50% of the population) **Chibabava** **Buzi**

Our project objectives are:

a. To decrease malnutrition (underweight) in children 0-23m from 26% to 18%.
b. To increase exclusive breastfeeding of children 0-5m 17% to 60%.
c. To increase feeding frequency of children 9-23m who are fed solid or semi-solids food at least three times daily from 33% to 65%.
d. To increase the proportion of young children fed nutrient-dense foods from 35% to 80%.
e. To decrease VAD by increasing the proportion of young children in Sofala who are regularly receiving vitamin A supplements from 82% to 95%.
f. To decrease VAD by increasing the proportion of children who consume Vitamin A rich foods from 29% to 80%.
g. To decrease helminthiasis and improve nutritional status by increasing the % of young children who are regularly dewormed from 70% to 95%
h. To increase the proportion of children 0-23m of age who participate regularly in growth monitoring/promotion activities from 70% to 90%.
i. To increase the proportion of young children with diarrhea who are given ORT in order to decrease dehydration and death from 71% to 90%

j. To increase feeding of young children during diarrhea (offering the same amount or more food during the illness) from 31% to 60%.
k. To increase the proportion of mothers of young children who are competent in preparation of ORS from 44% to 80%.
l. To increase the proportion of mothers of young children who know when to seek care for sick children (mothers who know at least three signs of childhood illness that indicate the need for treatment) from 29% to 75%.
m. Continue to expand usage and improve the Care Group model in Mozambique.
n. To increase to 80% the proportion of Leader Mothers trained in Integrated Management of Childhood Illness (IMCI) who can properly use the IMCI protocols for children 2-59m of age.
o. To increase to 80% the proportion of LMs who are able to do high-quality health promotion.
p. Increase the capacity of local partners and 90% of project communities to effectively address local health needs.

Food for the Hungry / Mozambique has been encouraged by AISPO's involvement with MOH health facilities and communities in Sofala province, and is requesting AISPO's help in extending this successful model of health status transformation in any of the above named districts, but especially in Chemba, Caia and Maringue.

Some of the responsibilities that Food for the Hungry would have in this project vis-à-vis AISPO would be:

1. to invite representatives of AISPO to participate in project trainings to include but not be limited to Care Group Modules, quality improvement and verification checklists, the Hearth nutritional rehabilitation model, data analysis and conducting mini-KPC (Knowledge, Practice and Coverage) surveys and anthropometry.
2. to regularly share program results and information regarding this Expanded Impact Child Survival program via Child Survival S Coordination team meetings, annual reports and an annual review meeting with AISPO.

We are inviting AISPO to participate by:

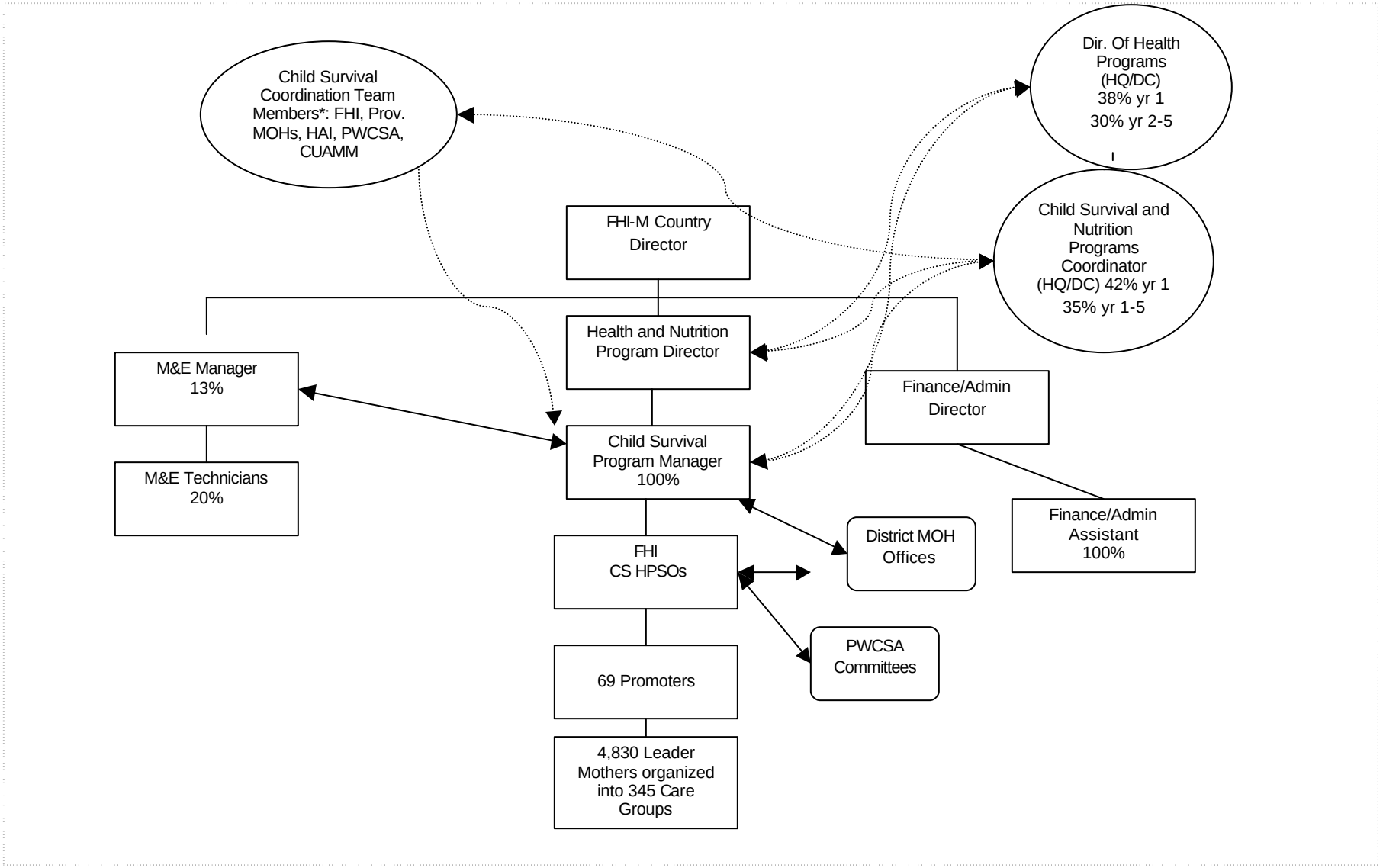
1. being involved in the development of Care Group training lessons, and the training of MOH staff and Promoters using these lesson plans;
2. participating in meetings of the CS Coordination Team and regularly identifying ways in which the program can be strengthened given AISPO's health experience in Sofala province;
3. identifying ways in which the Care Group model and other methods used by FH/Moz in the CS program can be integrated into AISPO's current and future projects and activities in order to achieve better coverage and results;
4. helping to identify ways in which we can all integrate this community-based health system in the curative care system established by the MOH of these districts; and
5. identifying ways in which AISPO can help share project costs – as funds are available – for training of Leader Mothers, supervision of Promoters and Care Groups so that the gains achieved through the project can be sustained.

Our goal is that no child should die in Sofala province. At this point, I am hoping that we can agree on the above concerning the collaboration of AISPO and FH in this project. As AISPO considers further funding for the aforementioned districts, we can enter into more detailed discussions about how FH and AISPO can share in this task of transforming the health status of the children and women who will be affected by this project.

Sincerely,

Thomas P. Davis Jr., MPH

ANNEX 5: Organizational Chart/Management Plan



ANNEX 6: Resumes/CV's and Job Description of Key Personnel

THOMAS PHILIP DAVIS JR., M.P.H.
2536 Holcomb Road
Boonville, NC 27011

voice: (336) 468-1803, alt: (704) 638-6394 e-fax: (419) 791-0620
e-mail: Tom.Davis@fh.org Webpage: www.phcreations.com

- **Evaluation and Planning of Child Survival / Primary Health Care Activities and Projects:** Eighteen years of international field experience in planning, coordinating, implementing, and evaluating projects – as a consultant and employee – in Bolivia, Burkina Faso, Cambodia, Colombia, the Dominican Republic, Ethiopia, Guatemala, Haiti, India, Kenya, Mali, Mozambique, Peru, Paraguay, Tanzania, and Zaire (Congo). (Six years living in developing countries [two in Haiti, four in the D.R.].) Experience in working with USAID centrally- and mission-funded Child Survival projects, privately-funded PHC projects, and Title II health projects.
  - ***Recent workshop facilitation experiences:*** FHI nutrition and positive deviance workshops in Kenya, Mozambique, and Bolivia in 2004 and earlier. Workshop Facilitator for KPC 2000 TOST Workshop, Myrtle Beach, SC (June 2002). Lead Facilitator for the Title II Nutrition Works Workshop in Millwood, VA (Sept. 2001).
  - ***Recent USAID evaluation experience:*** Wrote portions of Curamericas' baseline KPC report and DIP for Guatemala, 2003. Consultant for Counterpart/India's KPC baseline survey process in January 2001 (using the KPC2000+ and RapidCATCH questionnaires), in Africare/ Tanzania's baseline survey reporting in February 1998, and FOCAS/ARHC's baseline (1998) and midterm (Dec. 1999) evaluation. Worked with Dory Storms at Hospital Albert Schweitzer in Haiti to automate HIV/AIDS database on Pocket PCs.
  - **Recent CS backstopping experience:** HQ backstop for Curamericas' Guatemala CS project (until June 2003) and over all CS programs with Curamericas until June 2003. Mentor in the FOCAS/ Curamericas CS mentoring project in Haiti (1997 – 2003). Backstop to MAP Int.'s HQ staff for their MAP/Ecuador CS project (September 1999 - September 2001). Backstopping of FHI's Title II and HIV/AIDS work in Mozambique, Kenya, Bolivia, and Ethiopia.
  - **Recent DIP writing experience:** Wrote portions of Curamericas/Guatemala's DIP (2003). Lead facilitator in MAP, International's DIP in their Ecuador CS project in November 2000. Also, DIP writing for FOCAS/Haiti.
- **Evaluation and Execution of PHC/Child Survival Training Activities and Projects:** Eighteen years experience training community-level to post-graduate level health and community-development workers through ten organizations. Training areas included CS interventions and activities, Hearth/PD methodology and other nutrition activities, M&E, use of Pocket PCs in CS, nonformal education theory and methods, needs assessment, supervision, research skills, child safety, family planning, prenatal care, environmental health, community organization, computerized data analysis, and human rights abuse documentation. Have received training in the **Integrated Management of Childhood Illness** (IMCI). Trained in the census-based, impact-oriented (**CBIO**) approach to primary health care. Certified trainer in **CSTS' KPC 2000+ Survey Methodology**. Trained in **Lot Quality Assurance Sampling** (LQAS). Trained in the use of **Epi-Info 2002** (in 2003) and **Appreciative Inquiry**.

- **Languages:** Spanish (fluent written and spoken), Haitian Creole (fluent written and spoken), French (working knowledge: good reading/comprehension), working knowledge of Portuguese.
- **Behavior Change Communication (BCC) Evaluation & Materials Development:** Skilled in BEHAVE Framework and developer of Barrier Analysis methodology. Developed health education stories, songs, poems, skits, board games, codes, child-to-child exercises, and simulations.
- **Evaluation of BCC Activities and Projects:** Evaluated BCC methods and materials of organizations in Haiti, Mozambique, Kenya, Ethiopia, the Dominican Republic, Bolivia, Peru, Paraguay, Colombia and Guatemala; designed KPC surveys, observational checklists, and other evaluation tools.
- **Continuous Quality Improvement:** Designed CQI systems for a hospital for two years, and developed CQI tools and trainings for use in several countries.
- **Memberships:** CORE board member, CORE Social & Behavior Change Working Group, U.S. Coalition for Child Survival (Speaker's Bureau), APHA, Global Health Council.

JOB DESCRIPTION

Job Title: **Child Survival and Nutrition Program Coordinator**

SUMMARY

The Child Survival and Nutrition Program Coordinator (CSNPC) is located within Food for the Hungry's Government and Gifts-in-Kind Department in Washington, DC. The person who fills the position will be expected to provide technical support and some administrative backstopping to Food for the Hungry's (FH) (1) child survival and (2) food security capacity-building programs. The CSNPC will report to the Director of Food Security Programs, and will coordinate extensively with the Director of Health Programs.

ESSENTIAL DUTIES AND RESPONSIBILITIES include the following. Other duties may be assigned.

Key Result Area #2: Provides technical and administrative support for FH child survival programs (approximately 30% of time)

1. Serve as the primary child survival technical backstop for FH's Expanded Impact child survival project in Mozambique starting October 1, 2005 (and additional CS projects as funding is obtained).
2. Communicates regularly and visits with FH child survival field staff and provides requested program implementation support- especially for health and nutrition activities.
3. Ensures that FH child survival fields are aware of USAID reporting schedules and meet scheduled deadlines.
4. Lead author on child survival detailed implementation plans.
5. Reviews annual program reports and evaluations from child survival fields. Verifies that they are complete and accurate in addition to highlighting intervention areas that require support.
6. Liaises between USAID and FH child survival fields in responding to requests for information and documentation.
7. Coordinates with the Director of Food Security, Director of Health Programs, Grant Development Officer, and FHI field staff in supporting child survival program design and proposal development for USAID.

Lauren J. Erickson-Mamane, MPH

KEY QUALIFICATIONS

Over six years of international development experience. Ten years of project management experience in strategic planning, administration, supervision, and project evaluation both overseas and in the U.S. Expertise in maternal and child health, community health education, immunizations, disease eradication, capacity building, and personnel management of a culturally diverse staff. Background also includes writing grant proposals, securing project funding, preparing USAID reports, and submitting and managing annual budgets. Excellent communication and presentation skills. Computer skills include Microsoft Word, Excel, Power Point, Paradox and STATA. Proficient in English, French, and Hausa.

EDUCATION

Johns Hopkins Bloomberg School of Public Health, Masters of Public Health, May 2005

Washington and Jefferson College, Washington, PA - BA Psychology, 1993, *Cum Laude*

PROFESSIONAL EXPERIENCE

Manager, Program Coordination Unit (PCU) Africare/Niger Food Security Initiative
6/02 – 5/04

- Collaborated with Africare, CARE, Catholic Relief Services and Helen Keller International in implementing an innovative $20,000,000 USAID/DCHA/FFP consortium food security initiative in Niger, West Africa.
- Monitored project activities and their adherence to the detailed implementation plan. Activities included the development of community health and management committees, breastfeeding and weaning groups, micronutrient campaigns, vaccination programs, micro-credit programs, construction of community health centers, wells and irrigation systems, community capacity building, and agricultural and environmental protection projects.
- Supervised the realization of Food for Work activities to assure compliance with implementation strategy and project objectives.
- Participated in monthly steering committee meetings.
- Organized and facilitated quarterly program coordination meetings.
- Represented Africare in meetings with the Government of Niger and other NGOs.
- Spearheaded and facilitated the annual strategic planning meeting.
- Prepared quarterly and annual USAID/DCHA/FFP reports - Combined Recipient Status and Commodity Status Reports (CSR/RSR) and Cooperation Sponsor Results Report and Resource Request (CRS4).

Financial Coordinator, PCU Africare/Niger Food Security Initiative
11/00 – 6/02

- Developed and submitted HIV/AIDS and Democracy project proposals resulting in donor funding of $77,000.

- Performed all PCU administrative duties including vendors identification, price analysis, inventory, vehicle maintenance, payment of staff salaries, preparation of bi-weekly financial batches for Africare headquarters, and assured adherence to local employment guidelines.
- Tracked, managed and disbursed all funding received from monetized commodities and prepared financial reports for USAID/DCHA/FFP.
- Created and implemented annual financial work plans for all cooperating sponsors.
- Prepared annual PCU budget and coordinated submission of all cooperating sponsor budgets in accordance with USAID/DCHA/FFP guidelines.

Consultant, Peace Corps Niger
09/00 – 10/00

- Designed and implemented a West African guinea worm training for Peace Corps Volunteers and Associate Peace Corps Directors from Togo, Benin, Ivory Coast, Niger, Mali and Burkina Faso.
- Developed a West African Peace Corps guinea worm field manual.

Regional Representative, Global 2000 Niger, West Africa
09/99 – 09/00

- Managed the Carter Center's Regional Guinea Worm Eradication (GWE) field office in Zinder, Niger.
- Collaborated with the Nigerien Ministry of Health's National GWE program.
- Developed yearly eradication strategies that led to an 80% decrease in transmission rates.
- Spearheaded a 320% increase in chemical treatments of drinking water sources and managed the manufacturing and distribution of 43,000 filters to reduce incidence of Guinea Worm disease.
- Organized and implemented monthly rural community surveillance, community health agent training, treatment of contaminated water sources, community education programs and radio campaigns.
- Monitored 140 Guinea Worm endemic localities.
- Obtained project funding and managed all financial disbursements.

Community Health and Nutrition Extension Agent, Government of Niger/Peace Corps
06/97- 06/98

- Conducted community assessment survey in remote rural community to identify health care priorities.
- Performed community health education lessons focusing on malnutrition, oral rehydration, breast-feeding and weaning techniques, nutrition, hygiene, family planning, immunizations, gardening, micronutrients, and HIV/AIDS.
- Conducted baby weighings, immunizations and pre-natal examinations in a rural health clinic.
- Distributed polio and measles vaccinations in collaboration with the Ministry of Health during National Immunization Days.
- Implemented a water sanitation project that provided potable water to 950 village residents.
- Launched and facilitated regional women's work fairs to promote development and economic independence via income generation techniques.

- Collaborated and implemented projects in conjunction with other regional NGOs.

Operations Manager, Telespectrum Worldwide, Annapolis MD
1996-1997

- Managed, selected, trained and developed 15 supervisors for a premier supplier of telebusiness services.
- Directed call center staffing, productivity, and call quality to ensure client satisfaction.
- Developed supervisor skills in coaching, call monitoring, discipline, and motivation of marketing representatives as well as performed client specific training classes for marketing representatives.
- Conducted call center volume projections, staffing and capacity planning.
- Reviewed daily statistics to identify problems, recommend solutions and develop incentives to support the supervisory staff

III. TRAINING

- USAID Title II workshop, January 2003
- Africare P.L. 480 Title II CSR4 preparation workshop, March 2001
- Financial Management of USAID Awards training – Center for Public Management, February 2001
- USAID Administrative Compliance Requirements training – Center for Public Management, February 2001
- Peace Corps Training, Niger West Africa 1997 - Intense training in community health education, project
  planning, French, Hausa, and cross-culture.
- Telespectrum Worldwide Training of Trainers – Coaching, 1996

Job Description

Name	Emma Hernandez	
Position title	Child Survival Manager	
Department	Health	
Reporting to	Nutrition/Health and HIV/AIDS Manager	
Location	Beira, Mozambique	
Position type	National staff, full time and salaried	
Contract duration	Starting date: 01/10/05	Finishing date: 30/09/10
Functional links	Internal:	External:
Job summary	***The child survival program Manager is responsible for the day-to-day operations of the child survival project, organizes Child Survival Coordination meetings and establishes good working relationships with personnel of MOH and other NGOs in order to contribute to the overall improvement of public health practice in Mozambique.***	
Duties & Responsibilities	1. Together with the health programs manager, organizes quarterly Child Survival Coordination meetings, soliciting input for the agenda from each partner 2. Communicates with each HPSOs twice a week, and supervises their work through bimonthly visits to each district; meets with District MOH staff during these visits 3. Oversees all technical and financial aspects of the CS health program in Mozambique 4. Keeps a master schedule of all planned CS activities and tracks progress against plans 5. Together with the health manager develops and manages the HIS, defining required information and assisting staff in development of HIS reporting forms; issues Monthly Activities Reports, Quarterly Reports, and Items of Interest when new program developments occur, utilizing information from program participants 6. Contributes to the Detailed Implementation Plan, Annual Reports, Midterm Evaluation and Final Evaluation 7. Establishes quality improvement standards for FHI CS field staff and	

monitors results against objectives and requirements

8. Writes pre/posttests for each training, maintains data on pre/posttest scores in an organized fashion, and reports this data to others within FHI
9. Trains Promoters when necessary, and coordinates with the trainers of Promoters, HPSOss, and other staff to assure appropriate content in their training sessions; prepares training materials and conducts the remedial training of Promoters and other staff when necessary
10. Is available for consultation and trouble-shooting in difficult program problems in the field
11. Works towards understanding the vision, values, and purpose of FHI and is willing to demonstrate them in developing the FHI vision of community

* HIS means Health Information Systems

Emma Hernandez Avilan

Home address:
La Calera Cundinamarca
Colombia
South America
005718603580
e-mail**:** **emabarto@hotmail.com** or **emmabarto@yahoo.es**

Date of birth: April 01,1959
La Calera
Cundinamarca
Columbia

Special Skills:
Ten years experience with an International Non-Governmental Organization (NGO) in Angola, training people in relief -development situations and writing project proposals. Proficient in training health workers: Traditional Birth Attendants (TBAs), Maternal and Child Health (MCH) nurses, and training of training (TOT) for vaccinators.
Expertise includes organizing, planning, training, and managing community health programs with emphasis on EPI, Maternal and Child Health including HIV/SIDA

Summary of Experience:
Management Strategies for Improving Health and Family Planning Services, Monitoring and Evaluation Program
Worked closely with WFP in analysis, diagnosis and follow up of the general nutrition situation in the project sphere in IDPs Camps

Supervision of Regional Surveillance officers
Coordinated with other technical departments, local and international partners in the food security and nutrition sector in the project sphere.

Seven years working for Health Center (MOH) in Colombia in Maternal and Child Health, EPI, training and administrative activities; this time has been spent planning, monitoring, Epidemiological vigilance and give technical assistance. Over two years working with Pediatric Hospital give assistance in Newborn Service in Colombia

Employment

International Medical Corps(IMC)USA
Angola Program
Site Program Technical Coordinator
Huambo Province
August 2001 - Jan.2003

- Provided technical guidance and leadership to program staff implementing emergency Maternal Child Health, EPI, Traditional Birth Attendants and Family Planning including HIV/AIDS.

- Designed and implemented mechanisms which improved the development and implementation of IMC Child Survival programs.
- Collaborated with the technical staff in the identification and definition of new nutrition projects for the mission.
- Implemented and conducted follow-up and evaluation of food security projects.
- Implemented a Nutrition and Food Security Surveillance System and Component of the mission. Implemented a screening component in Bailundo IDPs demobilized camps.
- Responsible for overseeing program implementation activities. Supervised all technical personnel including the EPI Supervisor, TBA Supervisor, MCH Supervisor, and Social Mobilize. Made up the core program team and carried out program activities with the support of administrative and logistical personnel. Served as the liaison for provincial and municipal health authorities and other health-related agencies. Monitored field level program indicators.
- Management Strategies for Improving Health and Family Planning Services, Monitoring and Evaluation Program

International Medical Corps (IMC) USA
Angola Program
Site Manager & Technical coordinator
Huambo Province
August.1997-August2001

- Responsible for the administration of field offices and for monitoring security in the area.
- Supervised site logistician and administrative staff in the accomplishment of programmed interventions and worked closely with the Fin/Admin Manager.
- Responsible for the management and coordination of program activities.
- Served as point of contact for MOH, UNICEF, and all other health related agencies.
- Provided technical direction of field programs and directly supervised local supervisors. Also reviewed and analyzed all technical and program information. Monitored the program indicators at the country level.
- Provided information to the head of mission, food security coordinator, headquarters and field staff concerning general activities and project follow up in Huambo municipality IDPs camps.

International Medical Corps (IMC) USA
Angola Program
MCH Trainer
Huambo Province
Dec.1996-Aug.1997

- Trained Traditional Birth Attendants (TBAs), and Maternal and Child Health Nurses for a comprehensive reproductive health care program that integrated STI treatment, Therapy for AIDS patients, local training for health care personnel, and community-based education.
- Supervised MCH Programs installed in the Provinces.
- Management Strategies for Improving Health and Family Planning Services
- Distributed MCH medical supplies in every Health Post with MCH activities.
- Wrote monthly program report.

- Trained women's groups and leaders of the camp to how prevent and respond to gender-based violence in refugee/IDPS /conflict/settings.

International Medical Corps (IMC) USA
Angola Program
EPI Trainer
Huambo Province July.1996-Dec.1996
Kuanza Sul Province Feb.1995-Jul.1996
Cuando Cubango Aug.1993-Feb.1995

- Trained and supervised vaccinators and TOT and provided technical support to assure provincial cold chain.
- Organized and implemented vaccination campaigns in conjunction with the MOH.
- Conducted Epidemiological Vigilance.

La Calera Health Center (MOH)
Colombia Program
Nurse Coordinator
Bogota-Cundinamarca Mar.1986-July.1993Coordinated, monitored and evaluated of all activities of health programs.

- Conducted Epidemiological Vigilance.
- Wrote monthly and annual reports.
- Immunization activities during Polio Eradication's and Measles Campaigns.

Pediatric Hospital (MOH)
Colómbia Program
Nurse Coordinator of Newborn Service
Bogotá -Cundinamarca July.1984-March.1986

- Coordinated the supervision of the MCH Programs.
- Provided technical assistance for newborn care.

Education

Servicio Nacional de Aprendisaje Colómbia
B.Sc. in nursing
1980-1984
Professional register # 2064
MOH Colombia

Additional Qualifications

Universidad Pontificia Javeriana-Colombia
Community Health Nurse
Health Statistic and program activities
1990/1991

Workshops

The Joseph L. Mailman School of Public Health
Columbia University
RHR Consortium Monitoring and Evaluation:
Developing writing skill to share project results.
New York, NY
June.2002

International Medical Corps (IMC) USA
Gender-Based Violence
Angola
June 2002

The Joseph L. Mailman School of Public Health
Columbia University
RHR Consortium Monitoring and Evaluation Program
Prevention and Response to Gender-Based Violence in Refugee/IDPS /Conflict Settings
Mae Sot - Thailand
Jan.2002

RHR Consortium Monitoring and Evaluation Program
Monitoring Routinely Collected Data And Exploring HIV/AIDS Program
Entebbe-Uganda
June 2001

RHR Consortium Monitoring and Evaluation Program
Management Strategies for Improving Health and Family Planning Services
Washington D.C
Dec. 2000

Language Trainer center
Cape Town.
Completed pre- Intermediate level
May 2003 to August 2003
John Ambulance

Jun 2004 Up date of First Aid with emphasis in emergencies situation

Computer skills: Microsoft word, Excel, power point and EPINFO.

Other: Experience with HF and VHF telecommunications equipment(e-mail)

Languages Spoken:

Spanish	Excellent	Spoken and written
Portuguese	Satisfactory	Spoken and written
English	Intermediate	Spoken and written

ANNEX 7: Training and Technical Guidelines

Nutrition

DRAFT CARE GROUP TRAINER'S GUIDE

What every family should know about breastfeeding, child feeding, and hygiene.

Course overview:

1. Subject: **Importance of good nutrition and growth monitoring: breastfeeding, child feeding, and growth monitoring.**
    a. Practice: Teach back
    b. Holistic Lesson:
2. Subject: **Breastfeeding in the first six months: colostrum, early initiation of breastfeeding, optimal breastfeeding, overcoming challenges**
    a. Practice: Myth and Truth game about breastfeeding and Teach back
    b. Holistic Lesson: Myths and Truths about God's plan for us.
3. Subject: **Child feeding between 6months to 24 months breastfeeding, giving solid foods and active feeding.**
    a. Practice: Preparing good porridges for babies and children and teach back
    b. Holistic Lesson:
4. Subject: **When a child is sick: feeding a child during and after an illness (such as diarrhea)**
    a. Practice: Preparing good home fluids and teach back.
    b. Holistic Lesson:
5. Subject: **Good hygiene to prevent illness: hand washing, waste disposal, food preparation, food storage**
    a. Practice: Hand washing and teach back.
    b. Holistic Lesson:
6. Subject: **Good nutrition for the family: pregnant and nursing mothers, children age 2 to 5 years, and the whole family.**
    a. Practice: prepare and taste (or plan) some balanced menus and teach back
    b. Holistic Lesson:

Pre-Test: Document: Nutrition Pre-Test

Reminder: *At the beginning of each session:*

- *Seat participants so that everyone can see everyone else.*
- *Welcome participants, introduce your self, and have everyone introduce themselves.*
- *Thank the participants for helping with the program and encourage them in their efforts.*
- *Explain that they are the most important link in the program.*

I. Lesson 1 Importance of good nutrition and growth monitoring: breastfeeding, child feeding, and growth monitoring.

During this lesson we will discuss:

- Why is good nutrition important for babies and young children?
- Why is growth monitoring important?
- What are some good foods for children?
- What more do children need to grow and develop well?

Promoter: *Questions for the mother leaders*

Why is good feeding important for a child?
How can you tell if a child is growing well?

Note: Take time to listen to the mothers and find out what they already know. Don't correct wrong answers at this time. Thank the mothers for sharing from their experiences, and refer back to things they said as you present the lesson. Take care not to embarrass anyone.

Lesson:
Show figure one[36]***: Ask: Why is good feeding important for a child?*** As you said in our discussion just now, babies and children need a good diet for many reasons (as much as possible use the mothers' own words to cover these points):

- To be healthy and strong
- To keep warm, be active, to play and work and learn
- To protect against sickness: to be sick less often, to have less serious illnesses if sick, and to recover more quickly if sick.
- To grow and develop well in body, mind and spirit
- (Other correct things mothers said that you can remember)

Show figure two[37]***: Ask: Why is breastfeeding best for babies and mothers?***
As the group members have said, breastfeeding is very important for babies and young children. That's why it's so good that we breastfeed our children. God made us so that we can provide our babies with a food that is perfect for them.

- Breastmilk is the only food babies need for the first six months, giving them everything they need.
- Breastfeeding satisfies a baby's hunger and thirst.
- Breastmilk provides a perfect balance of nutrients so babies can grow well, keep warm, move and play.
- Breastmilk provides special disease protection elements that help a child get sick less often, less severely, and recover more quickly.

[36] Figure one: Healthy children.
[37] Figure two: Mothers breastfeeding

- Breastfeeding can prevent a mother from becoming pregnant again too soon.
- Breastfeeding can slow bleeding in a new mother, and can help her pass the placenta more quickly after giving birth, reducing the dangers to the mother from serious bleeding.
- Breastfeeding is free – it doesn't cost a family anything.
- Breastfeeding provides a child with its mother's warmth and love
- (Other correct benefits of breastfeeding that the mothers have mentioned).

Show figure three:[38] ***Ask: What are some very good, nutritious foods in our area (Sofala)?***

- The most important food for babies and young children is breastmilk, so the mother breastfeeding her baby is shown in the center of the picture
- When a child is ready to eat other foods in addition to breastmilk (at 6 months of age) it is time to add good mixed porridges and nutritious mashed foods to the child's diet.
- Some very good foods in our area include: maize, whole grains, broccoli, pumpkin, cassava, fish and beans. Children eating these foods are less likely to be malnourished.
-

Show figure four[39]: ***Ask: How can we tell our children are growing well?***

- It is very important to take our children to be weighed and measured to make sure they are growing well. Young babies need frequent growth monitoring, and older babies still need to be weighed regularly.
- If children are not growing well, it is very important to try to find out why not, and to follow the health worker's advice to remedy the problem. Otherwise, the child may be in danger of serious illness or death.

Show figure five[40]**: In addition to growth monitoring what are other ways we can see that a child is growing well?**

- Other signs that a child is growing well include bright shiny eyes, some fat on the body (but no swelling). The child is content after feeding, is seldom sick, and is lively, active and playful.

Show figure six[41]**: Ask**: **What does a malnourished child look like?**

- Explain that some will be too thin, others too short, and others will have swelling that makes them appear fat.
- A malnourished child does not have much energy to play, and gets sick easily.
- Talk about the difference between healthy fat and swelling (swollen faces, hands, feet, or swollen distended bellies are all signs of malnutrition, NOT signs of good growth).
- (Other correct signs that the mothers have mentioned).

---

[38] Figure three: good foods for children
[39] Figure four: growth monitoring
[40] Figure five: Healthy child
[41] Figure six: malnourished children

Ask: What does a child need in addition to good feeding to grow and develop well?
Figure seven[42]: Loving home: A loving and caring family, A clean, safe home, Safe water, Encouragement to play and learn

Figure eight[43] Health care when sick

Figure nine [44] Protection from accidents and infection
Figure ten[45] Vaccination to prevent many serious diseases

Also re-state other correct things mothers have mentioned that children need.

Summary: Review main points with the group, using the flip chart.

1. *Why is good feeding important for a child?*
2. *Why is breastfeeding best for babies?*
3. *How can we tell our children are growing well?*
4. *What are some nutritious foods in our area?*
5. *What more does a child need to grow and develop well?*

Questions and Answers: Ask the mothers what questions or doubts they have about the lesson. Discuss issues they are confused about. Also, tell them that they will be learning more about the topics in the coming weeks. Next week we will be talking more about breastfeeding.

Activity: Assumptions (this is adapted from Assumptions activity, p. 49 in PD/Hearth Manual).

1. Ask group to list what they believe to be the main causes of malnutrition. Write these down if paper and markers are available.
2. Challenge the group to identify which causes are "assumed" and not necessarily true.
   - If it has not already been mentioned, ask the group to consider whether or not a rich child can become malnourished.
   - Ask them to think about whether a poor child can be well nourished.
3. Discuss how nutritional status is not necessarily directly related to economic status.
   - People with more money may buy unhealthy treats, instead of giving their children good foods.
   - People who are poor may feed their families inexpensive foods that are very nutritious.

Practice: Have mothers break into groups of two or three, and practice teaching each other the main points from the flip chart.

---

[42] Figure 7: Loving home:
[43] Figure 8: Health care
[44] Figure 9: protection from accidents
[45] Figure 10: vaccination

II. Lesson 2 **Breastfeeding in the first six months: colostrum, early initiation of breastfeeding, optimal breastfeeding, overcoming challenges**

Reminder: *At the beginning of each session:*

- *Seat participants so that everyone can see everyone else.*
- *Welcome participants, introduce your self, and have everyone introduce themselves.*
- *Thank the participants for helping with the program and encourage them in their efforts.*
- *Explain that they are the most important link in the program.*

During this lesson we will discuss:

- Why it is important to begin breastfeeding soon after giving birth.
- Why babies only need breastmilk in the first six months of life.
- Ways to solve some common breastfeeding difficulties.

Promoter: *Questions for the mother leaders*

How soon after giving birth do mothers here usually begin breastfeeding their baby? Why do you think that is so?

Note: Take time to listen to the mothers and find out what they already know. Don't correct wrong answers at this time. Thank the mothers for sharing from their experiences, and refer back to things they said as you present the lesson. Take care not to embarrass anyone.

Lesson:

Ask: ***When is the best time to begin breastfeeding after giving birth?*** Listen to the mothers' answers.

Then Show figure eleven[46] and explain: Many mothers are surprised to learn that it is best to begin breastfeeding as soon as possible after giving birth, within the first thirty minutes. Some people have heard that they should wait longer, but now, doctors, nurses, health care workers and mothers are all learning that the sooner the better. There are many reasons why it is important to breastfeed as soon as possible:

- Breastfeeding helps the mother's womb contract to pass the placenta and to reduce blood loss in the new mother.
- Breastfeeding right away helps the child receive a special kind of breastmilk, called colostrum.
- Breastfeeding early and often encourages the mother's body to make more milk, more quickly so that she will have a plentiful supply of milk for her child.

[46] Figure eleven: Give colostrum right away.

- *Colostrum* is especially made for the newborn baby. It is special milk that is very nutritious.
- Colostrum gives the baby energy and protein, to keep warm and grow, and gives protection against infections and illness.
- Colostrum is very gentle to the baby's stomach and easy to digest
- Colostrum helps the baby pass the first bowel movements, which are a very dark and sticky stool and prepares the baby's stomach for regular breastmilk.

Ask: ***How often does a young baby need to eat?*** Listen to the answers the mothers give. Then show them the pictures (**Show figure twelve**[47]**)** and explain that a young baby needs to eat very often to grow well. Its stomach is very small and can't hold a lot of milk. Small babies need to eat very often, 10 to 12 times in a day and a night. This means that the young baby will be ready to eat every one to three hours. As they grow, they may go longer without getting hungry, but a three month old baby will still need to feed six or more times in a day and a night.

- Mothers should breastfeed a baby whenever it shows signs of hunger, and should wake a baby up and encourage it to feed if it sleeps too long without eating.
- Mothers should make sure the baby empties the first breast well before giving the second breast. Mother's can rub their babies and talk to them, to encourage them to keep eating.
- (Other correct things about breastfeeding that the mothers have mentioned).

Ask: what food or drink should a newborn have?
Show figure thirteen[48]**:**

- The milk from a mother's breast is the only food or drink a newborn should have, and the only food or drink it needs for the first 6 months of life.
- God made breastmilk to be exactly right for babies. Breastmilk changes as the child grows, to meet the child's changing needs.
- If a young baby (less than six months of age) is given any foods besides breastmilk, it can be dangerous, causing serious diarrhea and other illnesses.
- Giving a young baby (less than six months of age) water can fill up its stomach with water and it won't get enough milk to grow well. Also the water may be impure and can cause illness. It is best to give the young baby only breastmilk when it is hungry or thirsty.
- Sometimes special traditional herbal teas or foods are given to babies. But we recommend giving *ONLY* breastmilk in the first 6 months. If a mother wants her baby to receive special herbs or foods the mother should drink the teas and eat the special foods herself, and pass the benefits on to the baby through her milk.

Ask: How can we tell if a baby is feeding well at the breast?

[47] Figure 12: Breastfeed often, day and night
[48] Figure 13: Give only mothers milk for 6 months

Show figure fourteen[49]:

- The baby latches on well to the breast and the mother feels the baby's mouth pulling or tugging at the breast when it sucks, but feeding is not painful for the mother..
- The baby empties the first breast well before taking the second breast.
- The baby looks satisfied and relaxed or sleepy after feeding

Show figure fifteen[50]***Ask: Did you know that breastmilk is not always the same?*** It is always highly nutritious, but it changes during a feeding, to supply all the babies' needs.

- Colostrum is special milk for newborn babies; it is thick, very nourishing, protects the child from illness, and helps the child to move its bowels. Colostrum may be in many colors: yellow or brown or white or even clear but it is always very healthy for babies.
- After a few days the milk changes and mothers breasts feel very full and heavy. They have a lot of milk in them, and are also swollen. Later on, when this swelling and over-fullness has calmed mothers still are making a lot of milk for their babies.
- At the beginning of a feeding the first milk to come out is high in water and protein. Protein is good for building our bodies. Our bodies also need water, to satisfy thirst and prevent dehydration and to keep healthy. Breastmilk provides all the water a child needs. (Note: Sometimes a mother is surprised when a child asks to breastfeed, but only feeds for a minute or two, then doesn't want more milk. Perhaps the child was only thirsty, not hungry. The first milk to come down out of the breast at a feeding is very good at satisfying thirst. It is more watery and thin in appearance than other milk, and is called the foremilk or first milk.
- A little later in the feeding, the second milk, which is a whole milk, with a good mix of water, protein for growth, milk sugars for energy, and a little cream (fat, for energy and to keep the child warm). This milk looks whiter and richer.
- The last mil, or hind milk, is very high in cream. This milk helps a child gain weight and grow well. All children need some fat in their diets, and breastmilk supplies this fat in the perfect amounts for the young baby.
- These changes in the milk are why it is so important that a baby empty at least one breast very well during a feeding. Many babies will empty both breasts during a feeding.
- If the mother has an oversupply of breastmilk, it is better to empty one breast very well than to feed the child at both breasts every feeding. The child may be gassy and fussy, and not gaining weight well, in spite of the abundant milk supply, because the child is getting a belly full of the lower fat milk, but not enough cream.

---

[49] Figure 14: Empty the breasts well

[50] Figure fifteen: Foremilk, milk, and cream

- If the mother doesn't have a good supply of breastmilk she could feed until the first breast feels empty, and then empty the second breast, then return to the first breast. The first breast will have made some more milk and cream while the baby fed at the second breast. Also, extra feeding will encourage the mother's milk supply to increase.

Show figure sixteen:[51] Ask: ***What are some problems mothers may have when breastfeeding?***

Explain that most breastfeeding problems have a solution, if a mother gets the help and advice she needs to solve the problem. Someone who knows and understands a lot about breastfeeding should be able to help -- for example: an experienced mother, older woman, community health worker, traditional birth attendant, nurse or a doctor. In the case of problems it is important to **continue breastfeeding** and seek help.

Some common challenges include:

- Sore nipples
- Low milk supply or sometimes, too much milk
- Blocked milk flow and breast infections
- Becoming pregnant again
- Having more than one baby
- Mother or baby are sick

1. Sore nipples are most often caused by the baby not latching on correctly. The baby should be encouraged to open its mouth well and take a lot of nipple into its mouth. If it isn't latching well, it pinches the mother's breast so the milk doesn't flow freely, and causing pain for the mother.
2. Sore nipples can also be caused by a yeast infection. This is common in warm moist climates. Bathe the nipples with clear water after breastfeeding, and dry them gently with a clean cloth. This may help them clear up. Sunshine on the breast can also help (just a few minutes). If there is no improvement, and the skin is painful, seek help: an antifungal cream may be needed from the clinic.
3. If a mother has a low milk supply she should be sure the baby empties her breasts very well at each feeding, and should breastfeed more often. This will help to increase her supply within two or three days. Eating a little more food and resting more are also helpful in increasing the milk supply. It is usually best not to give the baby other foods or liquids when trying to increase the milk supply. In serious cases, seek medical advice.
4. If the mother has too much milk, or an overabundant milk supply, having the child empty only one breast per feeding, can help to calm the milk supply, as well as making sure the child receives the creamy hind milk. The mother can give both breasts if the child needs more milk, being sure to empty the first breast first.
5. In case of blocked milk flow and breast infections, sometimes this can be treated at home, by using warm cloths and massage to remove the blockages. The mother should continue breastfeeding frequently and rest in bed. If the blockages remain

[51] Figure sixteen: overcoming challenges to breastfeeding:

for more than 24 hours, or if the mother is ill and feverish, she should seek care at the clinic, and may need medication.

6. If the mother becomes pregnant again, her nipples will feel tender and sensitive, and breastfeeding will be less comfortable.
    - Many people used to believe that it was necessary to wean the baby when the mother became pregnant, but now we have learned that weaning can be harmful or dangerous for a young child who is not old enough to eat other foods well.
    - If the mother decides to wean, she should do so gradually and slowly while encouraging the young child to learn to eat other nutritious foods -- rapid weaning is not recommended.
    - To continue breastfeeding while pregnant, it is helpful if the mother can eat a little extra food, and rest more.
    - If the mother has other health issues or complications in her pregnancy, she should seek medical advice about breastfeeding while pregnant.
    - In most cases, the mother can continue to breastfeed and make good milk for her baby, and this will not harm the mother, the nursing child, or the unborn child.
    - It is even possible to continue to nurse the older baby along side the new baby, after it is born, without harm to either child.
    - Mothers can also make plenty of milk for twins or triplets.
7. If the mother or the baby become sick, in most cases it is best to continue breastfeeding.
    - In certain illnesses, such as tuberculosis medical advice is needed, about the risks of infection versus the risks of weaning, but in most illnesses in mother or child it is best to keep breastfeeding.
    - Breastfeeding has special elements in it to prevent illness in the child and to help the child get well quickly.
    - Breastfeeding also lets the mother rest while she feeds her child, so she can get well quickly.

Summary: Review main points with the group, using the flip chart.

1. *When is the best time to begin breastfeeding after giving birth?*
2. *How often does a baby need mothers' milk?*
3. *Why should a baby receive only breastmilk for the first 6 months?*
4. *How can we tell if a baby is feeding well at the breast?*
5. *How does breastmilk change during a feeding?*
6. *What can a mother do if she has problems breastfeeding?*

Questions and Answers: Ask the mothers what questions or doubts they have about the lesson. Discuss issues they are confused about. Tell them that next time we will be talking more about breastfeeding and child feeding between ages 6 months and 24 months.

Practice: Myth and Truth Game: Instruct mothers to listen to the statement that the group leader will read and wait for a signal. Then the group can shout out "yes" or "no"

afterwards. Quickly make sure everyone understands the answer before moving on to the next question, but don't embarrass anyone for giving the wrong answer.

Add some local myths or misconceptions about breastfeeding to the list as well. For example in some places woman have heard that they cannot breastfeed when they are angry, or that colostrum is bad.

Myth and Truth Game:

1. It is best to begin breastfeeding right away after giving birth. (YES)
2. If a mother has sore nipples she should stop breastfeeding. (NO)
3. Mothers can breastfeed even if they become pregnant. (YES)
4. Most breastfeeding problems cannot be solved. (NO)
5. Sick children should continue to breastfeed. (YES)
6. Breastmilk contains everything a child needs for the first six months of life (YES)
7. Mothers should encourage the child to empty the breasts well (YES)
8. If the mother is ill or tired she should rest and not give the child her breast (NO)
9. Giving other liquids or foods to a baby under six months of age can cause diarrhea and poor growth. (YES).
10. God has given us a perfect food for babies – breastmilk. (YES).

Teach the group the new breastfeeding song.

III. Lesson 3: **Child feeding between 6months to 24 months breastfeeding, giving solid foods and active feeding.**

a. Practice: Preparing good porridges for babies and children and teach back
b. Holistic Lesson:

Reminder: *At the beginning of each session:*

- *Seat participants so that everyone can see everyone else.*
- *Welcome participants, introduce your self, and have everyone introduce themselves.*
- *Thank the participants for helping with the program and encourage them in their efforts.*
- *Explain that they are the most important link in the program.*

During this lesson we will discuss:

- Why is it important to continue breastfeeding for two years or longer?
- When is a child ready for other foods in addition to breastmilk?
- How can we prepare good porridges for young children?
- How can we encourage young children to eat well?

Promoter: *Questions for the mother leaders*

When a child is old enough to eat other foods and liquids, why is it important to continue breastfeeding?
How can you tell when a child is ready to start eating porridge?

Note: Take time to listen to the mothers and find out what they already know. Don't correct wrong answers at this time. Thank the mothers for sharing from their experiences, and refer back to things they said as you present the lesson. Take care not to embarrass anyone.

Lesson:
Show figure seventeen[52]***:*** **Ask: What is the most important food for young children?**

- Breastmilk is the most important food for young children. It is the only food or drink babies need for the first six months of life, and it is still the most nutritious food for young children even when they begin eating other foods.
- That is why mothers should breastfeed babies first before feeding them porridge.
- That is also why it is recommended that mothers breastfeed their children for two years or longer.

Ask: How can you tell a child is ready to eat foods in addition to breastmilk? How do you begin offering foods to a child?
Around six months of age, children begin to show a sign of readiness to eat more things than just mother's milk.

- They may be beginning to sit up on their own, and may be getting teeth.
- They may be showing interest in what the family is eating and trying to put things in their mouths.
- They are old enough to control their tongues and swallow food without choking on it.
- (Other correct suggestions about feeding a child that the mothers have mentioned).

What should the first porridges for a child be like? (Papinhas liquidas)
Show figure eighteen[53]

- As a baby is just learning to eat, the first porridges will be thinner and soupier.
- The porridges should have a base of whole grain, such as maize, oats, millet, bulgur, or barley.
- A vegetable such as pumpkin or sweet potatoes, that is rich in vitamins, and easy to mash up well is a good addition to the first porridges.
- Many mothers like to add some milk from their breasts to sweeten the porridge and help the baby learn to like it, because of the familiar taste. It also makes the porridge more nutritious.

---

[52] Figure seventeen: Breastfeed the baby first before giving food.
[53] Figure eighteen: First porridge: enriched papinha liquida

How should a mother begin teaching her baby to eat?

- Prepare a simple, thin porridge such as one made of oats, pumpkin, and breastmilk.
- Breastfeed the baby before offering food.
- Sit the baby on the mother's lap, and offer a few tastes of porridge.
- Do not force the baby to eat, make feeding a happy, loving time.
- At first give the baby enriched porridge one time a day, and gradually increase to two times a day.
- Encourage the baby to take more porridge, and to learn to eat well.
- Gradually make the porridges thicker and encourage the baby to eat a larger portion.
- Begin to offer the baby 1 plate of mashed foods shared from the family dish for one meal, and 2 meals of enriched porridges.
- Continue to breastfeed first before feeding the child. Breastmilk is still the most nutritious and perfect food for young children, even when they are eating other foods.

Show figure nineteen[54]: ***Ask: What should the food for an older baby be like?***
As a baby grows and learns to eat well, they will begin to eat more foods.

- A child of nine months may be ready to share the family dish 2 times a day (while being helped to eat) to continue to eat enriched porridges 2 times a day as snacks. The child should still breastfeed before eating.

Show figure twenty[55]:

- A child between 1 year and 2 years of age will begin to eat 5 times a day – 3 meals (from the family dish) and two snacks of enriched porridge, while continuing to be breastfed.
- The child should continue to breastfeed up to two years of age or longer.
- The young child's stomach is small, and is not able to hold a large quantity of food at one time. This is why the child needs to eat frequently in order to grow well.

Show figure twenty one:[56] ***What are some healthy foods for children in our area?***

- Some very good foods in our area include: *maize, whole grains, broccoli, pumpkin, cassava, fish and beans.* Children eating these foods are less likely to be malnourished.
- Whole grains include *maize, oats, millet, bulgur, or barley.*
- Protein foods include *fish and beans,* also: ground nuts, seeds or nuts (sesame seeds, pumpkin seeds, almonds, ground nuts, or other nutritious seeds and nuts), legumes (any beans, cowpeas, pigeon peas, lentils) liver, kidney, meats, cheese or eggs.

---

[54] Figure nineteen: food for a baby who is learning to eat (about 9 months old)
[55] Figure twenty: food for a baby who has learned to eat well:
[56] Figure twenty one: healthy foods

- Vegetables: *Broccoli and pumpkin*, also: sweet potato, kale, spinach, collards, turnip greens, cassava, tomatoes and tomato paste, palm hearts
- Molasses, tomato paste and cocoa also are nutritious and may be added to some foods or drinks to make them taste good so the child will eat well and have a good appetite.

What are some good recipes for enriched porridges?

- The porridges should have a base of whole grains, such as maize, oats, millet, bulgur, or barley.
- The porridges should provide orange or green vegetables with Vitamin A
- The porridges should provide protein rich foods, such as fish or beans.
- The porridges should contain some oils or fats (gordura) from seeds or ground nuts, or added oils. If oils are available – 1 teaspoon of oil added to the child's portion of porridge.
- Remember to include a variety of nutritious foods. Sometimes it helps mothers to remember about variety to tell them about a colored bowl: Put foods of many colors in the child's bowl.

Show figure twenty two:[57] *Here is one recipe for a good first porridge: oats, pumpkin, and mothers milk, with a little boiled water if needed to make it thin enough for a child who is just learning to eat.*

- Be sure to mash everything until it is very soft, as if it has already been chewed.

- The porridge should have a base of whole grain such as maize, oats, millet, bulgur, or barley
- A vegetable such as pumpkin or sweet potatoes, that is rich in vitamins, and easy to mash well, is a good addition.
- Many mothers like to squeeze milk from their breasts into the first porridge to add protein and nutrition, and to make the porridge taste sweeter and more familiar to the child.
- Something with protein, such as lentils or beans, or ground nuts could be added.
- Sit the child on the mother's lap and give a taste of porridge.
- Make feeding a loving, happy time.

Figure twenty three [58]: *enriched porridge of maize, pumpkin, and beans and groundnuts*
Figure twenty four[59]: *enriched porridge of maize, fish, and greens, with a little oil*
Figure twenty five[60]: *enriched porridge of oats, broccoli, and ground sesame seeds*

[57] Figure twenty two: good enriched porridges
[58] Figure 23: enriched porridge of maize, pumpkin, beans, and groundnuts
[59] Figure 24: enriched porridge of maize, fish, and greens
[60] Figure 25: enriched porridge of oats, broccoli, and ground sesame seeds

Note to local FHI staff: These porridge recipes should be prepared locally, and tested to be sure they produce a good portion size to nutrient ratio. A small child cannot eat a large volume of food. These porridges can be adapted to rehabilitate malnourished children as well. If they are used for rehabilitation foods make sure the recipes contain 600-900 Calories, 20-26 grams of Protein, and 500 IU or more of Vitamin A in a portion that is appropriate for a small child (no more than 2 measuring cups of food or 4 small teacups or other local household measurement).

Summary: Review main points with the group, using the flip chart.

1. What is the most important food for young children?
2. How do you begin offering foods to a child?
3 How should a mother begin teaching her baby to eat?
4. What should the food for an older baby be like?
5. What are some healthy foods for children in our area?
6. What are some good recipes for enriched porridges?

Questions and Answers: Ask the mothers what questions or doubts they have about the lesson. Discuss issues they are confused about. Also, tell them that they will continue learning more in the coming weeks. Tell them that next week we will be talking about diarrhea, and about feeding a child during and after an illness.

Practice: As a group, prepare and taste some enriched porridges. While the porridges are cooking, have mothers break into groups of two or three, and practice teaching each other the main points from the flip chart.

IV. Lesson 4: **When a child is sick: danger signs, liquids and food for a child during and after an illness (such as diarrhea)**

a. Practice: Practice identifying danger signs, preparing and tasting home available fluids, and teach back.
b. Holistic Lesson:

Reminder: *At the beginning of each session:*

- *Seat participants so that everyone can see everyone else.*
- *Welcome participants, introduce your self, and have everyone introduce themselves.*
- *Thank the participants for helping with the program and encourage them in their efforts.*
- *Explain that they are the most important link in the program.*

During this lesson we will talk about:

- Determining when an illness with diarrhea has become an emergency
- Treating simple diarrhea at home
- Good fluids for treating diarrhea at home
- Getting sick children to eat and drink more during and after an illness such as diarrhea
- Praying for the sick

Promoter: *Questions for the mother leaders*

Review of Lesson 3

- ***What are some good enriched porridges for children to eat from age 6 months and upwards?***
- ***Why is breastmilk so important for children?***
- ***What are some very nutritious foods in our area that can help prevent malnutrition in our children?***
- ***Other (from bible lesson)***

Discussion of local methods

- Ask participants: What do people in your community believe causes diarrhea?
- Which of these beliefs are true and which are not true (discuss each belief)
- How do people in your community usually treat a child who is sick with diarrhea?
- Which of these practices do you think is helpful?

Note: Take time to listen to the mothers and find out what they already know. Don't correct wrong answers at this time. Thank the mothers for sharing from their experiences, and refer back to things they said as you present the lesson. Take care not to embarrass anyone.

Lesson:
Show figure twenty six[61]***:*** **How can we tell when an illness with diarrhea has become an emergency?**

- Simple diarrhea can usually be treated in the home.
- Sometimes diarrhea becomes serious – when it becomes an emergency the child must be taken immediately to the hospital, to prevent death from dehydration and illness.
- We should learn the danger signs so that we can recognize when diarrhea has become an emergency.
- Because every year millions of children die from diarrhea it is very important to teach mothers in the community how to determine how serious ill their children are.

Evaluating key signs and symptoms:

[61] Figure 26 Take the child immediately to the hospital: Use an IMCI graphic (or adapted graphic) on diarrhea and danger signs

CHECK FOR GENERAL DANGER SIGNS:
ASK:
1. Is the child unable to drink or breastfeed at all?
2. Does the child vomit everything?
3. Has the child had convulsions?
4. Has the child had blood in the stool?

LOOK:
1. See if the child is lethargic or unconscious
2. See if the child has signs of dehydration

Key Message

A child with any of these danger signs needs urgent medical attention. Take immediately to the hospital.

MENSAGEM CHAVE

Uma criança que tenha sinais de perigo, acima descritos, está com doença grave. Leve a sua criança imediatamente á Unidade Sanitária mais próxima

Evaluating Dehydration:

Severe dehydration

These are signs of **severe** dehydration (if any two of these are present):

- lethargy or unconsciousness
- sunken eyes
- skin pinch goes back very slowly (2 seconds or more)
- not able to drink or drinks poorly.

Severe dehydration is a danger sign. A child with any of these danger signs needs urgent medical attention. Take immediately to the hospital.

Some dehydration

If the child has *two or more* of the following signs, the child has **some dehydration:**

- restlessness/irritability
- thirsty and drinks eagerly
- sunken eyes
- skin pinch goes back slowly.

This should be adapted to Mozambique's IMCI protocols. I'm suggesting they learn danger signs, and signs of dehydration. Use the graphics that come with Mozambique's IMCI protocols. Use the community IMCI materials. Thank you!

Show figure twenty seven:[62] *Bloody diarrhea: this is an emergency*

- If you see blood along with diarrhea -- this is a danger sign
- The child must be taken immediately to the hospital

Show figure twenty eight:[63] *Child will not eat or drink: this is an emergency*

[62] Figure 27: *Bloody diarrhea: emergency*

- If the child is too weak or sick to eat or drink -- this is a danger sign
- If the breastfed child refuses mothers milk – this is a danger sign
- The child must be taken immediately to the hospital

Show figure twenty nine:[64] *Child is weak, lethargic or won't wake up: this is an emergency*

- If the child has no energy, and is very weak – this is a danger sign
- If the child doesn't move, or won't wake up – this is a danger sign
- If the child has fainted or is unconscious – this is a danger sign
- The child must be taken immediately to the hospital

Show figure thirty:[65] *Diarrhea persists for 2 weeks: this is an emergency*

- If diarrhea continues for two weeks, that is too long – this is a danger sign
- The child may lose too much weight or become dehydrated
- Diarrhea has become an emergency because it has gone on for two weeks.
- It is important to seek care for the child if diarrhea goes on for two weeks.

If the danger signs we just discussed are not present, most cases of simple diarrhea can be treated in the home Show figure 31[66]

- No medicine is needed for simple diarrhea.
- Give the child a lot of liquids and encourage the child to eat.
- Give the child extra hugs, attention and love.
- Pray for him or her and teach him /her to pray to the Lord for healing.

ASK: Why is it important to give a lot of liquid to a child who is sick with diarrhea?

- Good home liquids will help a child with many illnesses, such as colds and pneumonia, as well as diarrhea and vomiting, to recover quickly.
- Liquids are especially important when a child is losing fluids from its body by diarrhea or vomiting. Dehydration (drying out) can be very dangerous and can cause death in small children so it is very important to replace the fluids they are losing.
- (Other correct suggestions about giving liquids that the mothers have mentioned).

Show figure 32[67]***. When a baby who is under 6 months of age has diarrhea, what should it be given to drink? Ideally, Some group members will answer "mother's milk". Say, "That's right; breastmilk is the only food or liquid young babies need even when they are ill."***

- The baby less than six months of age should be given only breastmilk.
- The mother should offer the breast more often than usual, and keep on feeding even when the baby has vomiting and diarrhea.

---

[63] Figure 28: *Child will not eat or drink: emergency*
[64] Figure 29: *Child is weak, lethargic or won't wake up: emergency*
[65] Figure 30: *Diarrhea persists for 2 weeks: emergency*
[66] Figure 31: *Simple diarrhea can be treated in the home without medicine.*
[67] Figure 32: *Puro Pecho (only the breast) is all the baby needs until 6 months.*

- Even if the baby is just thirsty (not hungry) and wants to breastfeed for a few minutes, breastmilk is best for satisfying its thirst.
- Its fine to breastfeed in small amounts very often if that is what the sick baby wants, even 5 times in one hour
- Mother's milk is very gentle to the baby's stomach and will help the baby to get well quickly, providing the baby with a mother's love and warmth, food, liquid, and "medicine" all at the same time. God has made mother's milk to be a perfect food for the young child.
- Watch the baby carefully to see that the baby is urinating normally, and not getting dehydrated. Encourage the baby to breastfeed more often if it is not urinating normally.
- If the young baby will not breastfeed or shows other danger signs that we just discussed, this is not simple diarrhea – it is an emergency, and the baby must go to the hospital immediately.

Figure 33 [68] What should a baby <u>older than six months</u> of age be given when it has diarrhea?

- Some babies may not be very interested in eating or drinking when they are sick, especially if they are still beginning to learn to eat papinhas and other foods, but they may be very glad to breastfed. Being in mother's arms and receiving her milk is very comforting, and also gives good liquids and food.
- If a young baby (6 to 9 months old) refuses other foods and liquids, it can be breastfed, but must breastfeed more often than usual, to receive enough milk.
- Try to encourage the child to take good home liquids, papinhas liquidas and other foods. Encourage the child to drink and eat as much or even more than usual.
- Sweetening the liquids and food with molasses or another sweetener may encourage the child to take more.
- Some mothers may have heard that children who are ill should not eat a lot. We now know that this is not true, it is best for children to keep eating and drinking so they will be strong and get well quickly, to prevent dehydration (which is dangerous), and to keep the child from losing weight and becoming weak.

Show figure 34[69]: ***Ask: What are some good fluids for a child who is sick with diarrhea?***

- Mother's milk
- Papinhas liquidas
- Coconut water
- Rice water.
- Juice (Sumo)
- Oral Rehydration Solution

Show figure 35:[70] Encourage the child to eat.

---

[68] Figure 33: Older babies need breastmilk, foods, and liquids.
[69] Figure 34: Good home liquids.
[70] Figure 35: Encourage the child to eat

A sick child may have little appetite, but it is important to encourage the child to eat so that they don't become very weak or lose too much weight.

- Some mothers find that preparing special or favorite foods will be helpful in encouraging the child to eat something.
- Sometimes it can be help to add a little oil to the child's meals and snacks to increase the amount of energy the child will receive, even if he or she only eats a few bites. This makes the food more enriched or calorie dense.
- A sick child may enjoy sweeter foods than usual. For example, porridge can be sweetened with mashed fruit such as bananas, or sweet potatoes, and a little molasses
- Some mothers find that purchasing foods such as biscuits can encourage a sick child to eat more.
- Encourage the child to eat, sit with the child and feed it if necessary. Show lots of love and affection to make feeding time a happy time.

Feeding a child after an illness **Show figure thirty six:**[71]

- After an illness it is very important to give extra food for several weeks to help the child regain its strength, and to regain weight lost when the child's appetite was poor.
- If the child does not eat extra food after an illness, he or she is more likely to become ill again very soon, and to be at risk for malnutrition.
- After a child has diarrhea, feed the child an extra meal a day for at least a week to help the child regain weight that has been lost.

Figure 37[72]**:** Encourage the child to eat, sit with the child and feed it if necessary.

- Show lots of love and affection to make feeding time a happy time.

Figure 38[73]: Give special or favorite foods to help the child eat and regain a good appetite.

- Give the child extra hugs, attention and love. Pray for him or her and teach him /her to pray to the Lord for healing.

Show Figure 39[74]**: Help the child become strong again.** Doing these things will help the child become strong again, and less likely to become sick again very soon.

Summary: Review main points with the group, using the flip chart.

1. How can we tell when an illness with diarrhea has become an emergency?
2. What should a younger than six months of age be given when he or she has diarrhea?
3. What should a child older than six months of age be given when he or she has diarrhea?
4. Why should a child receive an extra meal for at least a week, after an illness?

Questions and Answers: Ask the mothers what questions or doubts they have about the lesson. Discuss issues they are confused about. Also, tell them that they will continue

---

[71] Figure 36: A child needs an extra meal every day for a week after being ill.
[72] Figure 37: Encourage the child to eat
[73] Figure 38: Give special or favorite foods
[74] Figure 39: Help the child become strong again.

learning more in the coming weeks. Tell them that next week we will be talking about good hygiene to prevent illness.
Practice: As a group, wash hands first, then prepare and taste some home fluids, also practice preparing and taste ORS if available. Review danger signs, and learn them by memory. Have mothers break into groups of two or three and practice teaching each other the main points from the flip chart.

V. Lesson 5: **Good Hygiene to prevent illness: hand washing, clean water, waste disposal, food preparation, food storage**
   a. Practice: Hand washing – mothers and children, Prepare clean water. Teach back.
   b. Holistic Lesson:

Reminder: *At the beginning of each session:*
- *Seat participants so that everyone can see everyone else.*
- *Welcome participants, introduce your self, and have everyone introduce themselves.*
- *Thank the participants for helping with the program and encourage them in their efforts.*
- *Explain that they are the most important link in the program.*

During this lesson we will talk about:
- Preventing diarrhea
- Hand-washing and bathing
- Preparing clean water
- Safe food preparation and storage
- Safe disposal of wastes

Promoter: *Questions for the mother leaders*

Review of Lesson 4

- ***What are some signs that diarrhea has become an emergency?***
- ***Why is it important to give a lot of fluids to children when they have diarrhea?***
- ***What else should we do to care for children at home when they have diarrhea?***
- ***How can we help children become strong again after they have been sick?***

Discussion of local methods

- Ask participants: What do people in your community believe causes diarrhea?
- Which of these beliefs are true and which are not true (discuss each belief)

Note: Take time to listen to the mothers and find out what they already know. Don't correct wrong answers at this time. Thank the mothers for sharing from their

experiences, and refer back to things they said as you present the lesson. Take care not to embarrass anyone.

Lesson:

Show figure forty[75]***:*** **Diarrhea is most often caused by eating or drinking things that are contaminated with feces.**

- The amount of feces is usually so small that you can't see it, but it is enough to make someone sick. Babies and young children don't have very strong stomach, so it is easiest for them to get sick from dirty hands or foods and liquids that are contaminated with feces. But it can make anyone sick.
- Feces can get into water in ponds or rivers, or an uncovered container of water.
- Feces can get on food and water from flies that have been on feces.

Show figure forty one[76]**Feces may be in the dirt where children are playing.**

- Young children always put their hands in their mouths, so feces get into their mouths that way.

Show figure forty two[77]

- It may be hard to believe that something you can't see can make you sick, but remember when you put poisons on an arrow, you can't see the poison but it will kill an animal.
- It's also like when you cut onions or garlic or fish, if you wipe your hand off after, the smell is still on your hands, even if you can't see anything on your hands.

Ask: ***How can we keep our food and water clean? What can we do to keep feces from getting into our children's mouths and stomachs and making them sick with diarrhea?***

Figure forty three[78] As we have been discussing, *a baby less than six months of age should be given only breastmilk. How does giving only breastmilk help to reduce diarrhea in babies under six months of age? Can feces get into a mother's milk?*

NO! Mother's milk is always clean

- Breast milk inside the mother's breast is always clean
- It doesn't spoil or go bad
- It can't cause diarrhea

Figure forty four[79]: *Hand washing is important*

- ***Hand washing has been shown to decrease diarrhea and to decrease child death***

---

[75] Figure 40: Flies on feces, then flies on food.
[76] Figure 41: Eating with dirty hands
[77] Figure 42: Woman changing a dirty diaper, then preparing food
[78] Figure 43: Mother's milk is always clean.
[79] Figure 44: Hand washing is important

- ***Even when hands look clean they may have a tiny amount of feces on them.***

Figure forty five[80]: Say: ***Clean drinking water is very important to prevent diarrhea. How can we get clean water?***

- You can filter out visible dirt and particles through a clean cloth, but the water still is not clean and safe to drink.
- Feces may be in the water even though you can't see it. It is easy for feces to wash into our wells, ponds, and rivers.
- The tiny germs from feces must be killed to make the water safe to drink.
- We can sanitize our drinking water by adding five drops of bleach (Javel or Jik) to a liter of water, and letting it sit for 20 minutes.
- Or, we can sanitize our drinking water by boiling it. Some people like to do this by putting a pot of water on the cooking fire to boil, right after cooking a meal. This is a good way to save firewood (lenha)
- After sanitizing our drinking water we should cover it so flies don't contaminate it again.
- Water that is not boiled or treated like this can make people sick. It is especially important that young children are given breastmilk, or liquids made with boiled or treated water.
- Some adults think they don't need to drink clean drinking water. But, if they start drinking it, they are often surprised to find that they feel better and get sick less often.

Figure forty six[81]: ***Why should food be covered after cooking, and only be kept for 24 hours after cooking?***

- We cover the food to keep flies from making it dirty with feces.
- In the same way that tiny germs or bacteria in feces can cause diarrhea, other germs from the air can grow in food if it is left too long after cooking, The germs spoil the food and can cause diarrhea.
- The food may not appear to be spoiled but can cause serious illness.
- Children can become very ill from eating food that is too old.
- Adults also can become very ill from eating old or spoiled foods.

It is best to prepare only the amount of food you can use in one day. *Cover food and only keep for 24 hours*

Figure forty seven[82]: ***Why should we use a latrine, or dig a hole and bury feces?***

- These are both good ways of making sure the feces are covered so they don't get on our children's hands and into their mouths.
- It keeps flies from getting on the feces, and then getting the feces into our food and water.

---

[80] Figure 45: Sanitize water
[81] Figure 46: Cover food and only keep for 24 hours
[82] Figure 47: Use a latrine, or dig a hole and cover feces

- Burying waste can also help keep rain from washing the feces into the river or pond.

Figure forty eight[83]: ***Why should we keep animals out of the house?***

- Animals may use the bathroom in the house.
- Animals may also walk through feces and bring them into the house on their feet.
- Then small children crawl in the feces. Then, they put their hands in their mouths and become sick with diarrhea.

Hand washing is very important. Good hand washing has been shown to decrease diarrhea and child death. When are the times we should wash our hands?
Figure forty nine[84]: After using the bathroom.
Figure fifty[85]: After cleaning up a young child after they have used the bathroom.
Figure fifty one[86]***:*** After cleaning a nose.
Figure fifty two[87]: After touching anything dirty.
Figure fifty three[88] Before preparing foods.
Figure fifty four[89] Before eating or feeding children.

See if the group can remember when to wash hands – tell them there are 4 "*afters*" and 2 "*befores*" to help them remember all the times. Let them look at the flip chart at first, and then see if they can remember without looking.

Summary: Review main points with the group, using the flip chart.

1. Preventing diarrhea by preventing contamination with feces
2. Hand-washing
3. Preparing clean water
4. Safe food preparation and storage
5. Safe disposal of wastes

Questions and Answers: Ask the mothers what questions or doubts they have about the lesson. Discuss issues they are confused about. Also, tell them that they will continue learning more in the coming weeks. Tell them that next week we will be talking about good hygiene to prevent illness.

Practice: As a group, practice washing mothers and children's hands. Have mothers break into groups of two or three and practice teaching each other the main points from the flip chart.

---

[83] Figure 48: Keep animals out of the house
[84] Figure 49: After using the bathroom.
[85] Figure 50: After cleaning up a young child after they have used the bathroom.
[86] Figure 51 After cleaning a nose
[87] Figure 52: After touching anything dirty
[88] Figure 53: Before preparing foods.
[89] Figure 54: Before eating or feeding children.

Alternative Practice: Sanitize water by putting 5 drops of bleach into one liter of water and letting it sit for 20 minutes. Taste the water. Compare the taste of boiled water and water with bleach and see what they like best. Have mothers break into groups of two or three and practice teaching each other the main points from the flip chart.

VI. Lesson 6: Good nutrition for the family: pregnant and nursing mothers, children age 2 to 5 years, and the whole family

a. Practice: Practice planning some balanced menus, and teach back
b. Holistic Lesson:

Reminder: *At the beginning of each session:*

- *Seat participants so that everyone can see everyone else.*
- *Welcome participants, introduce your self, and have everyone introduce themselves.*
- *Thank the participants for helping with the program and encourage them in their efforts.*
- *Explain that they are the most important link in the program.*

During this lesson we will talk about:

- Good nutrition for pregnant and breastfeeding mothers
- Good feeding for children ages 2 to 5 years
- Good foods for the whole family

Promoter: *Questions for the mother leaders*

Review of Lesson 5

1. What causes diarrhea?
2. Hand-washing
3. Preparing clean water
4. Safe food preparation and storage
5. Safe disposal of wastes

Discussion of local methods

- Ask participants: What do people in your community believe are good foods for pregnant women and new mothers? What foods do people believe pregnant women or new mothers should not eat?
- Which of these beliefs are true and which are not true? (discuss each belief)

Note: Take time to listen to the mothers and find out what they already know. Don't correct wrong answers at this time. Thank the mothers for sharing from their experiences, and refer back to things they said as you present the lesson. Take care not to embarrass anyone.

Lesson:

Show figure fifty five[90]***:*** **Pregnant women and breastfeeding mothers will be healthier, and their babies will grow better if they can eat more food: an extra meal or nutritious snack every day.**

Eat more food:

- Some people have believed that pregnant women don't need more food because they may not feel hungry. But, just as we should try hard to get a sick child to eat, a pregnant woman should try hard to eat, even if she is not hungry.
- Nursing mothers and pregnant women will be stronger, get sick less often, and will have stronger babies if they can eat a little more food than usual.
- Try to eat an extra meal or nutritious snack every day. Some mothers save and cover a plate of food from a meal they have cooked to eat later as an extra meal.
- Especially if a woman is thin and weak, it is important to try to eat more food, even if her appetite is not good
- As the pregnant or nursing mother gets stronger and healthier, her appetite will improve.

Eat healthy foods:

- The same foods that we talked about that are very healthy for babies are very nutritious for mothers (and the whole family).
- Maize and whole grains, broccoli, fish, beans, cassava, pumpkin, tomatoes, and eggs are excellent foods in this area.
- Other very good things are greens and green vegetables, sweet potatoes and carrots, ground nuts, seeds, lentils, peas, and organ meats.

Show figure fifty six[91]

Drink safe water:

- Mothers should also try to drink plenty of safe, boiled or sanitized water, or other good liquids (such as coconut water, cha, sumo, etc.)
- Putting 5 drops of bleach (Javik or Jik) into one liter of water and letting it sit for 20 minutes will sanitize the water.
- Some mothers get sick if they don't drink enough liquids.
- The liquid is also important for the unborn baby, and for making plenty of breastmilk.
- Drinking enough liquid also helps to prevent constipation in mothers.

Show figure fifty seven[92]

Take iron supplements:

- It is also recommended to take an iron supplement during pregnancy and during the first 6 weeks after giving birth.
- Taking iron prevents or treats anemia in the mother. Anemia makes women feel tired and weak.

---

[90] Figure 55: Eat one extra meal a day: Show a pregnant woman eating a meal, and around her or below her, pictures of four meals

[91] Figure 56: Drink sanitized drinking water

[92] Figure 57: Take an iron supplement

- Iron supplements prevent anemia in the mother and provides iron to the unborn baby, and to the nursing baby through mothers' milk.

Show figure fifty eight[93]

Rest more:

- Pregnant mothers and new mothers should try to rest more than usual, at least for a few minutes one or more times a day.
- Also, a woman who is having trouble making enough breastmilk can benefit from resting a bit more than usual, eating and drinking well, and offering the breast very frequently to her baby. Her milk supply will increase in just a few days by doing this.

Show figure fifty nine:[94] ***What do children between two and five years of age need to eat?***

Young children need 3 meals and 2 snacks

- Young children between 2 and 5 years of age will need to keep eating three meals a day and two snacks a day.
- Their bellies are growing, so they can eat more food, but they still need to eat often to grow well and be strong and healthy.
- As children gradually learn to chew better, their food does not need to be mashed up as much, but even a three year old child does not chew very well, and gets more nutrition if food is cooked soft of mashed so that they don't require much chewing. Nuts and seeds should be ground up, or pounded, or chopped for the same reason.
- Cutting the food in small pieces, or mashing it also helps prevent choking in a young child who does not chew its food well yet.

Figure sixty:[95] *Cover food to save for a snack*

- Some mothers save some food from the previous meal, cover it well to keep flies away, and give the plate of food to the young child as a snack between meals.
- Groundnuts and fruit such as coconut or papaya would be a good snack for an older child.
- What are some other nutritious foods in our area that would be a good snack for a child?

Figure sixty one[96]: *Enriched porridge*

- Many mothers continue to give enriched porridges to the children as a snack or meal.

Figure sixty two[97]: *Give clean water*

---

[93] Figure 58: Get more rest
[94] Figure 59: Young children need 3 meals and 2 snacks
[95] Figure 60: Cover food to save for a snack
[96] Figure 61: *Enriched porridge*
[97] Figure 62: *Give clean water*

- Young children should also be given clean water, and other liquids made with clean water, or juice.
- Boil or sanitize drinking water (with chlorine bleach or Javel (Jik) – 5 drops of strong bleach in a liter of drinking water).

Figure sixty three[98]: *Give mashed foods or small pieces of food*

- As children learn to chew better, their food does not need to be mashed up as much, but even a three year old child does not chew very well yet.
- The child gets more nutrition if food is cooked soft or mashed for easy chewing.
- Nuts and seeds should be ground up, or pounded, or chopped for the same reason.
- Cutting the food in small pieces, or mashing it also helps prevent choking in a young child who does not chew its food well yet.

Figure sixty four[99]: W*ash hands*

- Remember to help children to wash their hands before they eat meals and snacks, and after going to the bathroom.

Good nutrition for the whole family.

- The same foods that are good for babies, young children, and mothers are also very good for older children, adults, and elderly people.
- We will be learning about different food groups: we need to eat foods from each group to have healthy bodies. A varied diet is best: it is good to be eating a lot of different nutritious foods – not just the same thing every day. A colorful diet is good, too. Natural foods of bright or dark colors are often the most nutritious. For example, dark green vegetables and bright orange pumpkins have a lot of vitamins.
- Many foods contain several different kinds of nutrients. We will talk about large nutrients such as Grains, Proteins, Fruits and Vegetables, and Oils (gordura). We will also talk a little bit about smaller nutrients such as vitamins and other small nutrients (also called micronutrients) such as iron. Some people find it confusing when a food appears in several different lists, but that is normal. For example, organ meats provide protein, also Vitamin A, and also iron while nuts and seeds provide both protein and oil
- Fresh, home cooked foods are generally more nutritious than any packaged foods, such as crackers, packaged soups, chips or sodas. Packaged foods usually are expensive as well. If they are used at all, it should be seldom, perhaps as a special treat to encourage a child or person with no appetite to eat something. But they do not have as much nutrition as fresh, home cooked foods, so they should not be used very often.

Figure sixty five[100] ***Show the food square.***

---

[98] Figure 63: *Give mashed foods or small pieces of food*

[99] Figure 64: W*ash hands*

[100] Figure 65: Food square: Breastfeeding mother in center, **Grains**, **Proteins**, **Fruits and Vegetables**, **Oils**

1. ***How does food give us energy to work and play, make us grow, and keep us strong? (GRAINS)***
   - God has given us many good foods, and they contain everything we need to have good nutrition.
   - One very important group of foods is GRAINS. These foods give us the energy we need to work and play and to keep our bodies warm. Maize, Maize flour, oats, millet, bulgur, and barley are very good locally available grains.
   - We usually eat grains at every meal. Grain based, enriched porridge are very good snacks as well.

2. ***What foods do children need to grow? What foods build strong muscles? (PROTEIN)***
   - Protein foods are very important for growth. Children need protein to grow strong bodies, and smart brains.
   - Breastmilk provides good protein for young children.
   - Fish, beans and eggs are excellent sources of protein in our area. Other good protein foods include seeds and nuts (ground nuts, sesame seeds, pumpkin seeds, almonds, and others), legumes (beans, lentils and peas such as cowpeas and pigeon peas. Organ meats such as kidney and liver are also excellent sources of protein, as are other meats (fish, chicken, beef, pork, goat, and so on). Eggs and dairy products such as cheese also have plenty of protein.
   - Some people think that only meat and fish are good proteins, but many inexpensive foods such as beans and groundnuts also contain plenty of protein.
   - All people need to eat some protein food every day at least a couple of times a day. It is best to include a little protein food in the young child's dish at every meal and snack.

3. ***What foods do children and adults need to be healthy? What foods help prevent infection and illness? (Fruits and Vegetables)***
   - Vitamin A foods are especially important foods for good health and for preventing infection and illness.
   - Breastmilk contains vitamin A (as well as all the nutrients a young child under 6 months of age needs to grow well). But, as the baby grows older it also needs to receive Vitamin A from food.
   - Broccoli and pumpkin are two very good vitamin A foods in our area. They are rich in vitamins and many other nutrients. Children who eat these foods are less likely to become malnourished or ill.
   - Other good sources of vitamin A include sweet potato, kale, spinach, collards, and turnip greens.
   - Organ meats (kidney and liver) also contain vitamin A. Our bodies and the bodies of animals store vitamin A in the organs, which is why organ meats are a good source of vitamin A. They also contain other nutrients, such as protein.
   - It is best to eat a vitamin A food at least once a day.
   - Vitamin A helps prevent infection, and helps the sick recover more quickly from infections.

- Vitamin A also helps keep the eyes and skin healthy, as well as the ligaments that connect our bones.
- If a child does not receive enough vitamin A it may have eye problems, may lose its eyesight. Children with vitamin A deficiency also become ill frequently, and are at greater risk of dying from illness.

- ***What are some other foods that are rich in other vitamins?*** Broccoli, pumpkin, tomatoes, tomato paste, sweet potatoes, cassava, palm hearts, mango, avocado, banana, other local fruits and vegetables (only mention fruits or vegetables that are available locally).

4. ***What foods also give us energy, but are only needed in small amounts? (OILS – GORDURA)***
   - We have said that we need to eat grains, to have energy to move, work, and play, and keep our bodies warm. We also need to eat a little bit of oil, or foods that are rich in oils.
   - Everyone needs a small amount of oil or fat in their diet, everyday.
   - We don't need a large amount of oil. Some people have heard that if they give their children oil, they will gain weight better. They think, "if a small amount of oil is good, a large amount is better". But, that is incorrect. Too much oil can give a child diarrhea or loose stools.
   - Excellent sources of oil include ground nuts, almonds, sesame seeds, pumpkinseeds, and other seeds and nuts. It is best to pound them, or grind them up into a powder so that they can be easily added to foods. This makes them easy to digest. If they are left whole, children will not chew them well, and they will pass through the child's body, undigested. Sometimes adults, and older people don't chew well either.
   - Vegetable oils are another good source of oil. A teaspoon of oil can be added to a child's bowl of porridge to give more energy and to help the child grow well. Oil can also be added to the cooking pot.
   - If vegetable oils are not available in your community, don't worry. You can use ground up nuts and seeds, which are very nutritious and supply protein, in addition to oil.
   - Animal fats and lard, from fish or meats, also meet the body's need for oil (gordura). A little fat or lard can be added to the cooking pot. Just remember to use a small amount (about 1 or 2 teaspoons per person).

5. ***What have you heard about Vitamins and Micronutrients?***
   - There are many vitamins and micronutrients in foods that our bodies need in tiny amounts to grow and be healthy. We talked about Vitamin A, because it is so important for child health. There are many other vitamins as well, found in grains, protein foods, fruits and vegetables, and even in oils. There are also other things that we need in very small amounts such as iron, calcium, iodine and zinc are examples of important nutrients that we need in tiny amounts.
   - A good way to be sure that our diets include a lot of micronutrients is to eat a good variety of nutritious and foods in many different colors.

- Sometimes we need to take supplements of a certain vitamin or micro nutrient, if the nurse or community health worker suggests it for some reason.
- One very important micronutrient is iron. Pregnant women and new mothers may need to take iron supplements to prevent or treat anemia. If a woman doesn't have enough iron in her body, her blood will not be dark red, and she will feel weak and tired. Her baby may not grow well either, if she has anemia.
- Sometimes children also need treatment for anemia. They may need to take medicine to get rid of parasites in the body (such as worms, or the organism that causes malaria) as well as iron supplements.
- Iron can also be found in food, especially organ meats. It is recommended for a pregnant woman and a new mother to take an iron supplement daily. It is also good to eat organ meats when they are available.

Summary: Review main points with the group, using the flip chart.

- Good nutrition for pregnant and breastfeeding mothers
- Good feeding for children ages 2 to 5 years
- Good foods for the whole family

Questions and Answers: Ask the mothers what questions or doubts they have about the lesson. Discuss issues they are confused about. Also, tell them that they will continue learning more in the coming weeks. Tell them that next week we will be talking about good hygiene to prevent illness.

Note: At this point in the lesson it would be ideal to have examples of many local foods, or drawings of them. After teaching about the various food groups, people could practice sorting foods out: grains, protein foods, vegetables with Vitamin A, grains, other nutritious fruits and vegetables, oils, fats, and foods that are good sources of oils. Otherwise, the activities can be done just using the pictures in the flip chart.
OR: if a kitchen were available, and the group members had enough time, practicing cooking and tasting some nutritious recipes would result in more learning than simply talking about healthy foods.

Practice: ***Activity: Honoring Our Elders -- Traditional Meals:*** Ask mothers some traditional meals they remember their grandmothers preparing. Ask a volunteer (or more, if time permits) to show the ingredients from one of these traditional meals on the food square. Usually these traditional meals are very well balanced and nutritious. Tell the group that one way of showing respect, or honoring our mothers and fathers, is to apply the things we have learned from them – using their wisdom in our daily lives. *Then, break into groups of two or three and practice teaching each other the material from the flip chart.*

Alternative Practice I: As a group, practice planning healthy menus taking foods from each group shown on the food square on the flip chart (grains, proteins, vitamin A foods, other fruits and vegetables, and oils). (*Or, if time permits, and mothers are able to bring some foods, or organization is able to supply them, practice preparing and tasting some nutritious menus*). Plan what a mother could prepare and serve in the morning, mid-day

and in the evening, and what snacks she could serve her young children. Write the menu out on a sheet of paper or board, if available. *Then, break into groups of two or three and practice teaching each other the material from the flip chart.*

Alternative Practice II: If mothers are able to bring some foods, or organization is able to supply them, prepare and taste some nutritious foods that mothers in the group may not know how to prepare. Show on the food square why these foods are so nutritious. *Then, break into groups of two or three and practice teaching each other the material from the flip chart.*

ANNEX 8: Participants in the DIP Preparation Process

Start-Up Workshop

Name	Responsbility	Site
Joao Mafunda	FHI HPSO	Caia
Fatima Alexandre	FHI HPSO	Baira
Luciano Mafunda	FHI HPSO	Caia
Miranda Joao	FHI HPSO eventual	Grorongosa
Carolyn Wetzel	FHI Health and Nutrition Program Manger	Beira
Emma Hernandez	FHI CS Program Manager	Beira
Tom Davis	FH HQ Director of Health Programs	USA
Lauren Erickson-Mamane	FH HQ Child Survival and Nutrition Program Coordinator	USA
Mariano Abdul	DDS	Caia
Lopes Mangate	DDS	Marromeu
Emilio Suares	DDS	Gorongosa
Diogo Paquereque	DDS	Dondo
Florencia	HAI	Buzi
Serena Brusaneto	CUAMM	Beira
Anna De Farelo	CUAMM	Biera
Capitao Kianda	Salvation Army	Beira
Antonio Macario	PWCSA	Beira
Joao Madeira	Translator	Beira
Adriaan Korevaar	FHI/Moz Country Director	Beira
Julio Machava	HIV Provincial Coordinator	Beira
Luis Gonda	DAP Nutrition Provincial coordinator	Beira
Derrick Capurana	M&E	Beira
Anderson Munetsi	Finance	Beira
Rosario Carvalho	Human Resource Manager	Beira

DIP Workshop

Name	Responsibility	Site
Fatima Alexandre	FHI HPSO	Manga
Luciano Mete	FHI HPSO	Marromeu/Maringue
Joao Mafunda	FHI HPSO	Caia/Chemba
Derrick Capurana	FHI M & E	Beira
Wingi Olivier	DDS	Caia
Luciano Crisimo	DDS	Chemba
Lopes Mangate	DDS	Marromeu
Antonio F Balanca	DDS	Marringue
Dr Gussepe	AISPO	Chemba
Graca Efrone	PWCSA	Beira
Tom Davis	FH HQ Director of Health Programs	USA
Lauren Erickson-Mamane	FH HQ Child Survival and Nutrition Programs Coordinator	USA
Emma Hernandez	FHI CS Program Manger	Beira
Joao Madeira	FHI Translator	Beira
Samuel Singa	FHI Administrative Assistant	Beira

ANNEX 9: Beneficiary Table from PROPOSAL

Project Area: Sofala Districts	Total Population Served					Preschool Children (based on Yr 5)	Pregnant Women	Total Beneficiaries
	Year 1	Year 2	Year 3	Year 4	Year 5			
Caia (Sofala), 50%	97,482	100,671	103,964	107,364	110,876	9,314	2,218	11,531
Chemba	47,851	49,416	51,032	52,701	54,425	9,143	1,089	10,232
Maringue	65,792	67,944	70,166	72,462	75,150	12,625	1,503	14,128
Marromeu (Sofala), 50%	44,980	46,451	47,971	49,540	51,378	4,316	1,028	5,343
Cheringoma	12,060	12,454	12,862	13,283	13,775	2,314	276	2,590
Beira (Portion of pop. only)	83,150	85,870	88,679	91,579	94,977	15,956	1,900	17,856
Dondo			108,511	112,060	116,218	19,525	2,324	21,849
Gorongosa, 50%			104,555	107,975	111,981	9,406	2,240	11,646
Nhamatanda, 50%			135,719	140,158	145,358	12,210	2,907	15,117
Chibabava			76,867	79,381	82,326	13,831	1,647	15,477
Buzi			99,577	102,834	106,649	17,917	2,133	20,050
Machanga			48,865	50,463	52,336	8,792	1,047	9,839
Total	**351,314**	**362,806**	**948,766**	**979,801**	**1,015,448**	**135,350**	**20,309**	**155,659**

ANNEX 10: CURRENT Beneficiary Table

Project Area: District	Total Population Served					Calculated Children	Calculated Pregnant	Mothers of children 0-23 mths	Total Beneficiaries
	Year 1 (2005)	Year 2	Year 3	Year 4	Year 5				
Caia (Sofala), 50%	49,371	51,000	52,683	54,407	56,202	9,442	1,124	3,021	10,566
Chemba	42,301	43,697	45,139	46,615	48,154	8,090	963	2,589	9,053
Maringue	64,565	66,696	68,897	71,150	73,498	12,348	1,470	3,951	13,818
Marromeu (Sofala), 34%	31,725	32,763	33,844	34,951	36,105	6,066	722	1,941	6,788
Beira (Portion of pop. only)	105,854	109,347	112,956	116,650	120,500	20,244	2,410	6,478	22,654
Dondo, 50%			167,834	173,373	179,094	15,044	1,791	4,814	16,835
Gorongosa, 50%			89,475	92,428	95,478	8,020	955	2,566	8,975
Nhamatanda, 50%			191,027	197,331	203,843	17,123	2,038	5,479	19,161
Chibabava			66,904	69,112	71,393	11,994	1,428	3,838	13,422
Buzi			179,732	185,663	191,790	25,777	3,069	8,248	28,845
Total	**293,816**	**303,503**	**1,008,491**	**1,041,680**	**1,076,055**	**134,146**	**21,521**	**42,927**	**198,594**

ANNEX 11: Proposal Review

U.S. AGENCY FOR INTERNATIONAL DEVELOPMENT

Mr. Dave Evans
Food for the Hungry
236 Massachusetts Avenue, Suite 305
Washington DC 20002

Re: Child Survival and Health Grants Program Application Review FY 2005

Dear Mr. Evans:

I am pleased to inform you that the Food for the Hungry application submitted for Mozambique for the FY 2005 Child Survival and Health Grants Program was recommended for funding.

In order to prepare the cooperative agreement for Mozambique, the Office of Acquisition and Assistance will be contacting you shortly to begin negotiations and request additional budget information and/or clarifications. Once the Office has established that the application meets the standard U.S. Government regulations and guidelines, official notice will be sent by way of a cooperative agreement for signature. Until that time, you should not incur any expenses attributable to these activities. An orientation meeting for FY 2005 grantees will be held in early October to which your organization will be invited.

I want to congratulate you on your success in this very competitive process. The FY 2005 review process was extremely competitive due to the number and quality of applications submitted this year. Enclosed is a debriefing packet that provides a debriefing score sheet as well as a summary of the strengths and recommendations for your consideration during development of the detailed implementation plan.

We appreciate the effort that your organization devoted to preparing this application and thank you for your interest in USAID's child survival and health programs.

Sincerely yours,

Richard S. Greene
Director
Office of Health, Infectious Disease and Nutrition
Bureau for Global Health

1300 PENNSYLVANIA AVENUE, NW
WASHINGTON, DC 20523

GH/HIDN Child Survival and Health Grants Program
Debriefing Summary Sheet
FY 2005

PVO: Food for the Hungry
Country: Mozambique
Category: Expanded Impact

Categories	Entry	Standard	TB	Expanded
Number reviewed	11	12	8	10
Number funded	4	5	2	4
Highest score	N/A	N/A	N/A	95.50%
Lowest score	N/A	N/A	N/A	77.94%
% Overall Funded	25%	35%	15%	25%
PVO App. Rank	N/A	N/A	N/A	1
PVO App. Score	N/A	N/A	N/A	95.50%

Individual Category Scores for Expanded Impact : (Maximum Points in Parentheses)

Executive Summary	PVO Applicant	Situational Analysis	Program Strategy and Interventions	Performance M&E	Management Plan	Collaboration w/USAID Mission	Total Points
(2)	(3)	(25)	(25)	(25)	(15)	(5)	(100)
1.85	3	23.91	23.23	23.91	14.78	4.91	**95.50**

SUMMARY COMMENTS

Name of PVO applicant: Food for the Hungry

Name of Country: Mozambique

Application Category: Expanded Impact

EXECUTIVE SUMMARY

Strengths

The Executive Summary is extremely well written. It is concise, and provides an overview of the proposed program.

Weaknesses

This section would be further strengthened with a clear summary of the Care Group Model up front, since it is the central element of the whole program, which would then be expanded in this section and in the Program Strategy.

The Executive Summary should name all of the principal authors of the application.

DESCRIPTION OF THE PVO APPLICANT

Strengths

FH's purpose, mission, goals, annual budgets, major sectors of involvement and main methods of operation are clearly outlined and are congruent with the proposed project. FH is building upon a strategy which has demonstrated success in lowering malnutrition and improving results-level indicators in Bolivia, Mozambique, Kenya, and Ethiopia. The program is being extended to the selected sites at the request of the MoH. There is an opportunity to build upon the activities funded by PEPFAR, thus potentially expanding the scope and impact of the program.

Weaknesses

In comparison to their previous work, FH is proposing a target population of practically twice as many beneficiaries with only a 60% increase in the number of leader mothers.

SITUATIONAL ANALYSIS

Strengths

The Situational Analysis is extremely well prepared indicating a thorough analysis. This section provides a clear and comprehensive assessment of the relevant health status of the target population and clearly demonstrates the dire need for the interventions proposed. It includes the leading causes of maternal mortality and child morbidity and mortality. Data are clearly sourced.

The low beneficiary numbers (low for an Expanded Impact project) are explained by the geography of the area and difficulty of access.

Poor behavioral health practices and care-seeking by caretakers are identified and described. Barriers to accessing health care are well identified.

There is a comprehensive assessment of the socio-economic factors.

While activities with health facility staff will be coordinated, the main focus will be at the community and household level, where FH/M has experience and demonstrated impact.

There is a thorough discussion of the partners consulted and how they will work together to avoid duplication and maximize synergistic relationships and funding. FH plans to put aside funds to support the participation of other NGOs in training to encourage buy in and use of the Care Group methodology.

Letters of support from cooperating governmental departments and NGOs are attached.

FP's activities across food security (Title II), HIV/AIDS (PEPFAR) and MCH (CSGHP) provide an opportunity to demonstrate how these programs and "funding streams" can effectively synergize to address the comprehensive health and nutrition needs of this very vulnerable population. This is an opportunity for full evaluation and documentation.

Relevant stakeholders had input into the site and technical intervention selection.

Weaknesses

This section would be strengthened with a stronger case of need for the selection of the two provinces, going beyond the MoH request. Some of the rationale provided seems to raise more questions than answer them. For example, Zambesia was identified as having the severest diarrhea rates in the country, yet 76% of mothers in Zambesia, as opposed to 45% of mothers in Sofala, know about ORS. Ensure that data is consistently presented in ways which reflect its relevance in the context of the country's statistics.

Provide a more in-depth discussion concerning existing health centers, health posts, and hospitals, covering issues of access and quality of service. Include an explanation as to how FH identified the barriers to accessing care.

Include more description of food availability and access in this population, and how these elements of food security have been effectively addressed.

Even with the space constraints, provide some discussion on family planning, recognizing that delayed childbirth and child spacing are key determinants of maternal and child nutrition and health status.

Include a better definition of the links with PEPFAR and exactly what programs would be impacted and in what ways.

Clarify how the cost in USAID funds per beneficiary was calculated.

PROGRAM STRATEGY AND INTERVENTIONS

Strengths

Based on demonstrated knowledge of the population, the selected strategies and interventions correspond with the Situational Analysis and clearly support the stated goal and objectives of the FH/M project.

FH has linked the interventions to the Mission strategy and the CSGHP results.

The Program Strategy clearly describes how FH/M will work with the two provincial MOH offices, the DOH offices in the nine selected districts, and two NGOs.

The intervention areas are extremely well described in terms of their relevance to the health needs of women and children in the project target areas. They are further discussed in terms of the promotion of key household behaviors and care seeking practices, partner roles, fostering behavior change, training, and assuring equitable access and quality of care. FH clearly has sound knowledge of and experience working in the area of community IMCI.

FH recognizes that malaria (effects on appetite, anemia) and water are important for addressing nutrition.

Interventions are consistent with MOH policies concerning nutrition and micronutrients.

There is a focus on increasing capacity through the Care Group model (including extensive IMCI training) as a means to increase sustainability. Interventions are kept at low cost. There is a description of how the project will be scaled up.

Weaknesses

This section would be strengthened with a reduction in redundancy and further fleshing out of technical aspects.

It would have been useful and appropriate to have the program objectives included here in the text. Readers are instructed to refer to the next section to learn of the program objectives and then are referred again to an Annex.

Provide further discussion on ameliorating issues relating to transportation, beyond having leading mothers in isolated areas.

FH is encouraged to make zinc universally available and used as quickly as possible, dispensing with extensive evaluation, etc. MOST has developed programmatic guidelines. Dispersible zinc tablets can be procured directly from Nutriset in France. CSHGP can help with the waiver.

Early childhood care is going to be largely determined by the mother's health, which warrants a discussion of maternal health issues. Maternal anemia is a huge issue that has effects on birth outcomes (maternal and perinatal mortality, birth weight, development)

and subsequently on the mother's health. Document if women are getting adequate iodine, and the local accessibility/affordability of iodized salt. FH should consider the opportunity to ensure that women are getting iron/folic acid supplements in the antenatal and postnatal period, malaria prevention and treatment, antihelminthics, and potentially iodized oil supplements during antenatal care according to WHO recommendations. The structures are in place to add this.

Ensure that mothers do not receive a high-dose vitamin A supplement beyond 8 weeks postpartum, as it can be teratogenic in early pregnancy.

Within such a food insecure context, this section would be strengthened with more discussion on availability/access to local foods and vitamin A, ensuring that children over two do not fall through the gaps. Discuss where added oil and vitamin A rich foods would come from, going beyond the existence of Care Groups.

With HEARTH workshops every 6 months, children could wait as long as 5-6 months to get into a HEARTH program. Rather than being restricted by the HEARTH methodology and keeping it walled-off from the CG IYCF/GMP activities, consider incorporating the principles of HEARTH within the CG bi-weekly/monthly counseling sessions to address the special needs of these malnourished children (of benefit to all mothers).

The severely malnourished will be referred to facilities despite evidence that the community-based therapeutic care (CTC) model using ready-to-use therapeutic food (RUTF) may be a better option which could perhaps be introduced on a pilot basis.

Provide additional information on time allocation requirements for promoters and Leader Mothers, compensation, and how these may or may not present constraints/challenges for long-term sustainability. Include in the discussion the turnover for these positions, and any retention problems.

Describe how key inputs for Care Group use are procured, e.g. ORS, vaccinations, antihelminthics, antibiotics, chlorin.

Include a time/phasing-in table for scale up to provide greater clarity.

PERFORMANCE MONITORING AND EVALUATION

Strengths

The M&E plan is well thought out, clearly articulated, and realistic. There is a table outlining the results-based objectives, indicators, and major activities, frequency of data collection and method of verification. There is a focus on sustainability issues.

Baseline and end line studies are included and have a budget.

The MOH has expressed interest in learning to use the new HIS forms and tools that will be part of the project.

Indicators are consistent with globally accepted standards and match program objectives.

A number of operations research areas have been identified in the application, all of which correspond with and will enhance implementation of the project activities. FH/M will carry out a study to examine the reasons of success of the Care Group model.

Weaknesses

Include a discussion/identification here of the M&E expertise to be attached to the project in Mozambique, expanding on the reference in the Management Plan. Provide justification for why this position is only 25 percent LOE for M&E activities.

Include further discussion on the strength and/or weaknesses of the MoH system as well as how the two systems might be integrated.

FH will need to add an indicator for zinc.

The exclusive breastfeeding indicator should be for six months, rather than 9 months.

MANAGEMENT PLAN

Strengths

Clear organizational and financial management structures are in place to enable the management of this project.

There is an emphasis on bringing partners together regularly.

FH plans to phase in a transition of supervision of the Promoters from the District Coordinators to the Provincial MoH staff.

Sufficient and appropriate human resources, including headquarters backstopping, are devoted to the program.

The project work plan reflects the program approach and activities as reflected in the budget.

Weaknesses

This section would be strengthened with one organizational chart which clearly delineates the roles and responsibilities of both HQ and the field as an integrated whole.

Include further discussion on the practical issues surrounding the creative idea of having the some of the coordination facilitated through a virtual classroom.

The management and human resources table needs to be strengthened to more clearly indicate FH's plans. It needs to include a discussion on the roles and responsibilities of FH staff as well as partner staff. Indicate how many M&E technicians are attached to the project. Better illustrate the LOE of partners.

The work plan would be improved by using a delineated time/phase/year/quarter table, which would make is easier to visualize how the activities flow. As a suggestion, identify the main and sub-project activities in the left hand column with recognition given in the following columns as to when these activities would take place.

FH may want to consider OR on the recurrent inputs to keep the Care Groups going effectively.

COLLABORATION WITH USAID FIELD MISSIONS

Strengths

The proposed program is congruent with the USAID-Mozambique Strategic Objective 8, as well as identified intermediate results.

The attached letter from USAID-Mozambique indicates strong support and endorsement.

Weaknesses

None identified.

OVERVIEW COMMENTS

The project appears viable with a great deal of potential as an expanded impact program. FH clearly has a great deal of solid experience and expertise in the area of maternal and child health.

The number and lettering of items in the Program Strategy section need some clarification. It would have been helpful to have program objectives readily available in the appropriate section.

FH has articulated the Care Group Model and Community IMCI providing a very clear sense of what this project might look like at the ground level. The MoH is developing a Community Participation Strategy which could incorporate the experience of the Care Groups.

Although there is difficulty finding qualified Mozambican staff, FH is encouraged to include more Mozambican staff in key positions

In order to ensure sustainability of this program, FH should ensure more MoH involvement in implementation, especially on the behavior change communication component.

ANNEX 12: QIVL

CHECKLIST FOR EDUCATION SESSIONS BY COMMUNITY DEVELOPMENT WORKERS (HWs)

Name of HW:_____ Evaluator:_____
Community: _____ Date: _____

METHODS	YES	NO
1. Did the Health Worker (HW) seat people so that all could see each others' faces?	❒	❒
2. Did the HW open the session in prayer (if appropriate in the local context)?	❒	❒
3. Did the HW wear appropriate clothing?	❒	❒
4. Did the HW sit at the same level as the other participants?	❒	❒
5. Did the HW use a participatory method? (game, skit, song, story, other -- SPECIFY:_____)	❒	❒
6. Did the HW introduce the topic well (who s/he is, topic, time)?	❒	❒
7. Did the HW ask questions to relate the topic to the participants' experiences?	❒	❒
8. Did the HW use the brainstorming technique at appropriate moments?	❒	❒
9. Did the HW speak loud enough that everyone could hear?	❒	❒
10. Did the HW use proper eye contact with everyone?	❒	❒
11. Did the HW use changes in voice intonation (not monotone)?	❒	❒
12. Did the HW speak slowly and clearly?	❒	❒
13. Did the HW move around the room without distracting the group?	❒	❒
14. Did the HW use any props?	❒	❒
15. Did the HW demonstrate any skills that s/he was promoting?	❒	❒
16. Did the HW verify that people understood the main points using open-ended questions?	❒	❒
17. Did the HW summarize the essential points presented at the end?	❒	❒
DISCUSSION		
18. Did the HW ask the participants lots of (non-rhetorical) questions?	❒	❒
19. Did the HW give participants adequate time to answer questions?	❒	❒
20. Did the HW encourage discussion amongst participants?	❒	❒
21. Did the HW encourage comments by paraphrasing what people said (repeating statements in his or her own words)?	❒	❒
22. Did the HW ask participants if they agree with other participants' responses?	❒	❒
23. Did the HW encourage comments by nodding, smiling, or other actions that show s/he was listening?	❒	❒
24. Did the HW ALWAYS reply to participants in a courteous and diplomatic way?	❒	❒
25. Did the participants make lots of comments?	❒	❒
1 2 3 4 5 6 7 8 9 10 Poor Excellent		
26. Did the HW prevent domination of the discussion by 1 or 2 people?	❒	❒
27. Did the HW encourage timid participants to speak/participate?	❒	❒
28. Did the HW summarize the *discussion*?	❒	❒
29. Did the HW reinforce statements by sharing relevant personal experience, or asking others to share personal experience?	❒	❒
CONTENTS		
30. Was the content of the educational messages CORRECT?	❒	❒
1 2 3 4 5 6 7 8 9 10 Poor Excellent		
31. Was the content of the educational messages RELEVANT?	❒	❒
1 2 3 4 5 6 7 8 9 10 Poor Excellent		
32. Was the content of the educational messages COMPLETE?	❒	❒
1 2 3 4 5 6 7 8 9 10 Poor Excellent		
33. OVERALL EVALUATION OF THE HW's EDUCATIONAL PERFORMANCE: 1 2 3 4 5 6 7 8 9 10 Poor Excellent		

Comments: _____

Annex 13: Care Group Report Form

Monthly Care Group Report for the Month of _____ / _____ (month/year)

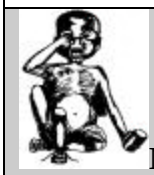
Care Group Number :_____ Care Group President: _____

Community : _____ Promoter: _____

Number of LMs Reporting this month: _____ Number of LMs in this group: _____

Leader Mothers	Children						Women					
	 No. of Children 0-23m seen	 Deaths of children 0-23m	 Malnourished	 Vit A distribute	 Deworming Meds distributed	 No. of children attending GMP	 No. of Women Seen	 Women current pregnant	 Pregnant women receiving prenatal care	 Total Lactating Mothers this month	 No. of lactating mothers who received iron	 Total live births
LM #1 SELF												
LM #2												
LM #3												
LM #4												
LM #5												
LM #6												
LM #7												
LM #8												
LM #9												
LM #10												
LM #11												
LM #12												
LM #13												
LM #14												
TOTAL												

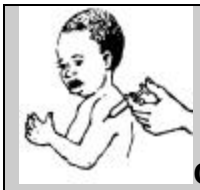
ANNEX 14: Tally Sheet for Promoter Monthly Report
Month/Year: _____/_____

Item	Make Hatch Marks (////)Here		Total	Module Covered / Comments
 **Care Group Teaching Sessions**				
No. of Care Group Teaching Sessions held				
Leader Mothers Attending Care Group Sessions				
 **Screening Posts**			**Total**	**Comments**
No. of Screening[101] Posts held				
Children seen at Screening Post				
 **Malnutrition Screening**			**Total**	**Comments**
Normal	0-11:			
	12-23:			
	24-59:			
M1 (Risk of Malnutrition)	0-11:			
	12-23:			
	24-59:			
M2	0-11:			
	12-23:			
	24-59:			
M3	0-11:			
	12-23:			
	24-59:			
Edema	0-59:			

[101] A screening post is where you weigh children 0-59m of age (every 6 months) to screen them for malnutrition, as well as dosing them with Vitamin A and Mebendazole.

Deworming, Micronutrients, and ORS

Deworming, 12-59m			
Deworming, Pregnant women			
Iron supplements, pregnant women			
Vitamin A doses, children			
Vit. A doses, nursing mothers			
Children recvg ORS packets			



Children Immunized by MOH (at Screening Post)

Any vaccines	0-11:		
	12-23:		
	24m+:		

Women Immunized	**Pregnant Women**	**Women who are Not Pregnant**	**Prg.**	**NP**	
Any TT					

Children Deaths (this period only)

Child Deaths	0-11m:		
	12-23m:		
	24m+:		

Promoter: _____

Date: ____/____/____ **Signature:_____**

Annex 15: FH/Mozambique
Program Manager's Monthly Report

Program Manager: Emma Hernandez **For Month/Year:**

Activities and Coverage	Target	Actual
No. of Care Group Meetings		
Number of Mothers Educated		
Number of GM/P Posts		
Children seen		
Mothers seen		

Trainings in Past Month:

Topic #1: _____ Training Agency: _____

Trainees:	**Number**
Coordinators	
Promoters	
LMs	
M&E Specialists	
TBAs	
Other	

Average Pretest: 0.00% Average Post-test: 0.00%

Topic #2: _____ Training Agency: _____

Trainees:	**Number**
Coordinators	
Promoters	
LMs	
M&E Specialists	
TBAs	
Other	

Average Pretest: 0.00% Average Post-test: 0.00%

Topic #3: _____ Training Agency: _____

Trainees:	**Number**
Coordinators	
Promoters	

LMs			
M&E Specialists			
TBAs			
Other			
Average Pretest:	0.00%	Average Post-test:	0.00%

Stock-outs of Materials Material / Medicine	Available? (Yes/No)	Comments
Vitamin A		
Deworming medicine		
Vaccine (at MOH assisted posts)		
Antibiotics		
Iron supplements		
ORS packets		
Zinc		
Forms (e.g., growth charts)		
Equipment (e.g., scales)		
Other		

Nutrition Activities and Coverage	Target	Actual
Vitamin A capsules given to children		
Vitamin A capsules given postpartum		
Pregnant women receiving iron sulfate		
Children receiving deworming medicines		

Morbidity and Mortality Patterns	Cases 0-2m	Cases 3-11m	Cases 12-59m	Referred
Diarrhea				
ARI only				
Pneumonia				
Pneumonia Follow-up Forms:				
➢ Complete Forms				
➢ Follow-up at 2 days				
➢ Correct Classification				
Diarrhea Follow-up Forms:				
➢ Complete forms				
➢ Follow-up at 1 day				
➢ Correct Referral				
Vital Events:				
Deaths of children, 0-59m of age	***0-2m***	***3-11m***	***12-59m***	

Births				
New pregnancies				
All deaths of women during pregnancy/ within 45 days of birth, any cause:				

QI Checklists Used This Month	Number of Staff members observed	Average Score
1. Group Education		
2. Individual Education		
3. IMCI		
4. Growth Monitoring / Promotion		
5. General Services		
6. Checklist of Supervisors' use of QI checklists		
7. Other (Specify)		
8. Other (Specify)		

Observations on use of QI Checklists:

Children seen at GM/P post: *(See Target Coverage Charts)*

Maternal and Newborn Data	Count
(Need to list things here that we want to measure regularly – see indicators)	
Women who receive postpartum visit in first 7 days	

Field Visits by CS Program Manager:

Date	District	Activity Observed (e.g., Care Group)	Purpose/Findings/ Comments

Activities Planned for Next Month & Related Needs:

Project Narrative **(Discuss current situation including meetings, visitors, contracts/ agree-ments, progress on grants/proposals/fundraising, census/vital event activities, problems/issues, trips, continuing education, etc.):**